Name: __________________________
Address: _______________________
Height: __________ Weight: _______
Age: ________ Male/Female: ________

1. Do you snore?
   - Yes
   - No
   - Don't know

If you snore:
2. Your snoring is?
   - Slightly louder than breathing
   - As loud as talking
   - Louder than talking
   - Very loud - can be heard in adjacent rooms

3. How often do you snore?
   - Nearly every day
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
   - Never or nearly never

4. Has your snoring ever bothered other people?
   - Yes
   - No
   - Don't know

5. Has anyone noticed that you quit breathing during your sleep?
   - Nearly every day
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
   - Never or nearly never

6. How often do you feel tired or fatigued after your sleep?
   - Nearly every day
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
   - Never or nearly never

7. During your waking time, do you feel tired, fatigued or not up to par?
   - Nearly every day
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
   - Never or nearly never

8. Have you ever nodded off or fall asleep while driving a vehicle?
   - Yes
   - No

If yes, how often does this occur?
   - Nearly every day
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
   - Never or nearly never

9. Do you have high blood pressure?
   - Yes
   - No
   - Don’t know

10. BMI >30
    - Yes
    - No

Scoring questions: Any answer in a white box is a positive response.
Scoring categories:
Category 1 is positive with 2 or more positive responses to question 1 - 5
Category 2 is positive with 2 or more positive responses to question 6 - 8
Category 3 is positive with 1 positive response to question 9 -10

Final results: If 2 or more categories are positive, you have a high likelihood of sleep apnea.