Adult Sleep Apnea Questionnaire

1. Have you gained more than 10lbs in the past year?
   ☐ Yes ☐ No
2. Do you snore at night?
   ☐ Yes ☐ No
3. Do you stop breathing for some periods at night?
   ☐ Yes ☐ No
4. Are you restless at night?
   ☐ Yes ☐ No
5. Do you hit, kick or slap your bed partner?
   ☐ Yes ☐ No
6. Do you sleepwalk?
   ☐ Yes ☐ No
7. Do you have morning headaches?
   ☐ Yes ☐ No
8. Has anyone complained about disturbing changes in your personality?
   ☐ Yes ☐ No
9. Do you have trouble maintaining attention & concentration?
   ☐ Yes ☐ No
10. Do you have insomnia?
    ☐ Yes ☐ No
11. Are you extremely sleepy or fatigued during the day?
    ☐ Yes ☐ No
12. Do you wake in the middle of the night with heartburn?
    ☐ Yes ☐ No
13. Do you nod off occasionally?
    ☐ Yes ☐ No
14. Are you forgetful, confused or “spaced out” at times?
    ☐ Yes ☐ No
15. Do you wake up frequently during the night?
    ☐ Yes ☐ No
16. Do you have or are being treated for high blood pressure?
    ☐ Yes ☐ No

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