Sleep Disordered Breathing Questionnaire

We are screening all of our patients for sleep disordered breathing. This is a serious life threatening condition that effects 1 in 3 adults.

Height _____inches Weight_____lb BMI_____

Age_____ ☐Male / Female☐ Neck Circumference*_____inches

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors?
   ☐ Yes or No ☐

2. Do you often feel tired, fatigued or sleepy during the daytime?
   ☐ Yes or No ☐

3. Has anyone observed you stop breathing during your sleep?
   ☐ Yes or No ☐

4. Do you have or are you being treated for high pressure?
   ☐ Yes or No ☐

5. Is your BMI more than 35 lb/in^2?
   ☐ Yes or No ☐

6. Age over 50 years old?
   ☐ Yes or No ☐

7. Neck circumference greater than 16.5 inches (male) / 15 inches (female)? (staff will measure)
   ☐ Yes or No ☐

8. Gender male?
   ☐ Yes or No ☐

High risk: answering yes to three or more items

Low risk: answering yes to less than three items Patient Name_____