CEDAR VALLEY CARDIOVASCULAR CENTER
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Sleep Apnea Questionnaire

Name:_____ Date of Birth:_____ Date:_____

1. Do you have diagnosed Sleep Apnea? YES NO
   If YES, please answer question #2.
   If NO, please skip to question #3.

2. Do you use a prescribed CPAP or BiPAP? YES NO
   If NO, Why not?

_____

_____

_____

_____

3. Do you regularly feel un-refreshed, even after waking from a full night's sleep? YES NO

4. Do you fall asleep easily during your waking hours, while at home or at work? YES NO

5. Are you a loud, habitual snorer? YES NO

6. Has your bed partner witnessed you choking, gasping, or holding your breath during sleep? YES NO

7. Do you often suffer from poor concentration or judgment, memory loss, irritability and/or depression? YES NO

Sleep Apnea Clinic Checklist

Epworth Sleepiness Scale

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (Even if you have not done some of these things recently, estimate how they would affect you.) Use the following scale to choose the most appropriate number for each situation:

0 = Would Never Doze
1 = Slight Chance of Dozing
2 = Moderate Chance of Dozing
3 = High Chance of Dozing

Situation:	**Chance of Dozing:**
Sitting and Reading	_____
Watching TV	_____
Sitting Inactive in a Public Place (Theater)	_____
As a Car Passenger for an Hour without a Break	_____
Lying Down to Rest in the Afternoon	_____
Sitting and Talking to Someone	_____
Sitting Quietly After Lunch without Alcohol	_____
In a Car, While Stopping for a Few Minutes in Traffic	_____
Total Score:	_____

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