

## NSMC SLEEP CENTER SLEEP APNEA SCREENING QUESTIONNAIRE

1. Do you snore on most nights? ( 3 or more nights per week )

YES= 2                      NO= 0

2. Is your snoring loud? ( can it be heard through doors or walls )

YES= 2                      NO= 0

3. Has anyone ever told you that you stop breathing or make loud gasping sounds when you sleep?

NO= 0    YES= 3    FREQUENTLY= 5

4. Do you now or have you ever had a heart condition or high blood pressure?

YES= 2                      NO= 0

5. Do you occasionally fall asleep or tend to doze when:

a) In your car at a stop light?

YES= 2                      NO= 0

b) Whenever you're in active for more than 30 minutes?

YES= 2                      NO= 0

**SCORE:**

<b>5 POINTS OR LESS</b>	<b>6-8 POINTS</b>	<b>9 POINTS OR MORE</b>
Low probability of sleep apnea	Significant chance of sleep apnea. Talk to your MD.	High chance of sleep apnea. See your MD as soon as possible to discuss scheduling a sleep study.