



NORTH SHORE
MEDICAL CENTER

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?

YES= 3 FREQUENTLY= 5 NO=0

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 doze when in your car or at a stop light?

YES= 2 NO= 0

6. Do you occasionally fall asleep or doze when you're active for more than 30 minutes?

YES= 2 NO= 0

SCORE:

5 points or less Low probability of sleep apnea

6-8 points Probability of sleep apnea. Talk to your MD

Above 9 points High probability of sleep apnea. See your MD to discuss scheduling a sleep study.