Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep Apnea - Self-Test

Do you experience any of these problems?

* \_\_\_\_ Unintentionally falling asleep during the day
* \_\_\_\_ General daytime sleepiness (even when you had enough sleep)
* \_\_\_\_ Wake feeling unrefreshed
* \_\_\_\_ Have difficulty concentrating and remembering things?

\_\_\_\_ Do you ever wake from sleep with a choking sound or gasping for breath?

\_\_\_\_ Has your bed partner or others noticed that you snore loudly (louder than talking or loud enough to be heard through closed doors)? ­­­­­­­­­­­­­­­­­

\_\_\_\_ Has your bed partner or others noticed that you stop breathing while you sleep?

Other questions you can ask yourself to determine if you are at higher risk for sleep apnea include:

\_\_\_\_Have you ever nodded off or fallen asleep while driving?

\_\_\_\_Do you often wake up with a headache?

\_\_\_\_Do you have a neck size of 17 inches or more? (men)

 16 inches or more? (women)

\_\_\_\_Do you have a body mass index (BMI) of 30 or higher?

\_\_\_\_Do you have (or are being treated for) high blood pressure and / or cardiac issues?

\_\_\_\_Do you have (or are being treated for) Type 2 diabetes?

Do you have a family member who has sleep apnea?

IF YOU CHECKED SOME OF THESE BOXES, ASK YOUR DOCTOR IF YOU

SHOULD BE EVALUATED FOR SLEEP APNEA OR ANOTHER SLEEP DISORDER