Date ____________________

Hosmane Cardiology-Patient Sleep Questionnaire

Full Name ____

Date of Birth ____

Insurance____________________________________ PCP: ____________________

Currently using CPAP: Y/N **Tested for Sleep Apnea within the last 12 months: Y/N**

If you have answered YES to either question above, please do not complete below.

WHY ARE WE ASKING ABOUT YOUR SLEEP?

SLEEP APNEA

- MAY INCREASE YOUR BLOOD PRESSURE
- MAY INCREASE YOUR RISK FOR ATRIAL FIBRILLATION
- MAY INCREASE YOUR RISK FOR STROKE
- MAY INCREASE THE RISK OF DIABETES AND OBESITY

PLEASE ANSWER THE QUESTIONS BELOW:

- DO YOU SNORE LOUDLY? YES / NO
- DO YOU OFTEN FEEL TIRED OR SLEEPY DURING DAYTIME? YES / NO
- HAVE YOU NOTICED OR BEEN TOLD THAT YOU STOP BREATHING OR CHOKE DURING SLEEP? YES / NO
- DO YOU HAVE OR ARE YOU CURRENTLY BEING TREATED FOR HIGH BLOOD PRESSURE? YES / NO
- ARE YOU MALE? YES / NO
- ARE YOU OVER 50 YEARS OLD? YES / NO
- HEIGHT ____________________
- WEIGHT ____________________

WE WILL TAKE IT FROM HERE!

----------Office Use Only. Please do not write below this line--------

BMI > 35 Kg/m2? YES / NO

HOW MANY QUESTIONS ABOVE ARE ANSWERED “YES”? --------------

*YES TO 3 OR MORE = AT RISK FOR SLEEP APNEA

Order WatchPAT: YES/NO

PLEASE CONTINUE TO NEXT PAGE