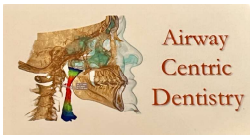

Sleep Quiz

Full Name | Practice Name

Home Address | City, State ZIP Code

Mobile Phone | E-mail Address

☐ Female ☐ Male

Date of Birth | Gender (*check off*)

Complete the following questionnaire to the best of your abilities by circling the answer to each question. Answers to these questions will help us determine how well you rest at night and the likelihood that you might be suffering from a life-threatening condition.

				Score
1.	**Has anyone told you that you stop breathing while asleep?** *If yes, who? How often? (daily, weekly, etc.)*	Y	N	4
2.	**Have you ever been involved in any type of accident because you nodded off or fell asleep?** *If yes, tell us more.*	Y	N	3
3.	**Have you ever nodded off or fallen asleep while driving?** *If yes, how often? When was last time?*	Y	N	3
4.	**Have you woken up suddenly gasping for air, heart racing or with shortness of breath?** *If yes, how often? (daily, weekly, etc.)*	Y	N	3
5.	**Do you grind your teeth?** *If yes, have doctor circle dental wear severity: mild moderate severe*	Y	N	3
6.	**Do you snore or has someone ever told you that you snore?** *If yes, how often? (daily, weekly, etc.)*	Y	N	3
7.	**Does anyone in your family have a history of snoring or sleep apnea?** *If yes, who? Snoring or sleep apnea?*	Y	N	3
8.	**Do you feel tired or sleepy throughout the day?** *(daily,weekly, etc.)*	Y	N	2
9.	**Does it take you less than 10 minutes to fall asleep?** *If yes, how many minutes?*	Y	N	2
10.	**Does it take you more than 20 minutes to fall asleep?** *If yes, how many minutes?*	Y	N	2
11.	**Once you fall asleep, do you have trouble staying asleep?** *If yes, tell us more.*	Y	N	2
12.	**Do you find it difficult to manage your weight?** *If yes, tell us more.*	Y	N	1
13.	**Do you suffer from headaches during the morning or during the night?** *If yes, how often? (daily, weekly, etc.)*	Y	N	1
	MEDICAL HISTORY			
14.	**Have you been diagnosed with high blood pressure or take medication for it?**	Y	N	3
15.	**Do you suffer from acid reflux?**	Y	N	3
16.	**Do you suffer from heart disease or have you had a stroke?**	Y	N	3
17.	**Have you been diagnosed with a sleep disorder?**	Y	N	3
18.	**Have you stopped using your CPAP device?**	Y	N	3
19.	**Are you wearing your CPAP less than 5 times per week?**	Y	N	3
	Please add the total score corresponding to your YES answers:			

Based on the total score you entered above, circle the Risk Level listed below.

RISK LEVEL	LOW RISK	MODERATE RISK	HIGH RISK	SEVERE RISK
RANGE TOTAL	0 TO 3	4 to 5	6 to 7	8 +

☐ By checking this box I consent to receive notifications and updates via text and email about sleep-related procedures, including treatment.

Patient Signature: _____

Form courtesy of: Sleep Architects, Inc.