

Sleep Studies Screening

Name: _____

Date of Birth: _____

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| 1) | I have been told that I snore. | Yes/No |
| 2) | I have been told that I stop breathing when I sleep,
although I have no recollection of this. | Yes/No |
| 3) | I am always sleepy during the day even when I have
slept throughout the night. | Yes/No |
| 4) | I have high blood pressure. | Yes/No |
| 5) | I have been told that I sleep restlessly.
I am always “tossing and turning”. | Yes/No |
| 6) | I am overweight. Current weight _____ | Yes/No |

Total Circled “Yes” _____