



# SLEEP APNEA ASSESSMENT

Some of the questions are best completed by a bed partner if you have one as they refer to symptoms that occur during your sleep.

|   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1) <u>Do you snore loudly (loud enough to be heard through closed doors)?</u> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) <u>Do you often feel tired, fatigued, or sleepy during daytime?</u>        | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) <u>Has anyone observed you stop breathing during your sleep?</u>           | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) <u>Do you have or are you being treated for high blood pressure?</u>       | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) <u>BMI more than 34 KG/m<sup>2</sup>?</u>                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) <u>Age over 50 years old?</u>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) <u>Neck circumference greater than 40 cm or 15.7 inches?</u>               | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) <u>Gender male?</u>  | <input type="checkbox"/> | <input type="checkbox"/> |
|   | TOTAL SCORE              | <u>    </u> <u>    </u>  |

To calculate your BMI, click here → <http://www.nhlbisupport.com/bmi/bmicalc.htm>

If 3 or more questions are answered YES, you should discuss Sleep Apnea with your Doctor.  
This test is very general in nature and does not replace information or advice from a Healthcare Professional.  
If you suspect that you have OSA contact your physician.