Northwest SLEEP HEALTH

Sleep Assessment

Thank you for taking the time to fill out this screening questionnaire. Your practitioner will be reviewing these answers to determine if further testing for sleep apnea should be administered. If testing is indicated, **Northwest Sleep Health** will contact you. Should you have any questions regarding sleep, please call 503.353.1272.

Name: _____ DOB: _____ Age: _____ Date: _____

Height: _____ Weight: _____ Gender: F M

Primary Care Physician: _____

Do you snore?	☐ Yes	☐ No
Have you been told you stop breathing during your sleep?	☐ Yes	☐ No
Do you wake gasping, coughing, or choking for air?	☐ Yes	☐ No
Do you frequently have morning headaches?	☐ Yes	☐ No
Do you experience frequent daytime sleepiness, even after a full night's rest?	☐ Yes	☐ No
Is your neck greater than 17" (Male) or greater than 16" (Female)?	☐ Yes	☐ No
Are you overweight?	☐ Yes	☐ No
Do you have a BMI of 30+? (Nursing Staff will calculate BMI_____)	☐ Yes	☐ No
Do you fall asleep easily while driving?	☐ Yes	☐ No
Do you use any medications, prescription or non-prescription, devices or equipment to help you sleep?	☐ Yes	☐ No

How long? _____

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