



Concierge Sleep Medicine

Sleep Study at the comfort of your home.

Sleep Apnea Quiz

Have you been told that you **SNORE**? Yes No

I've been told that I **STOP** breathing while I sleep. Yes No

I have **HIGH** blood pressure. Yes No

My family say they have noticed **CHANGES** in my personality. Yes No

I am **GAINING** weight. Yes No

I sweat **EXCESSIVELY** during the night. Yes No

I have noticed my **HEART** pounding or beating irregularly at night. Yes No

I get morning **HEADACHES**. Yes No

I have **TROUBLE** sleeping when I have a cold. Yes No

I suddenly wake up **GASPING** for breath during the night. Yes No

I am **OVERWEIGHT**. Yes No

I seem to be **LOSING** my sex drive. Yes No

I feel **TIRED** during the day even when I sleep through the night. Yes No

If you marked *Yes* three or more times, you may show symptoms of *Sleep Apnea*, a life-threatening disorder that causes you to stop breathing repeatedly often several hundred times a night while you sleep.

This questionnaire is meant to be a source of education to help you and your physician decide if you need help or further evaluation. It should not be used for diagnosis or treatment purposes.

If you show symptoms of a sleep disorder for more than two weeks, please take this form to your physician.