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## SLEEP HEALTH DISORDER CHECKUP

| | | |
|---|---|---|
| Have you been told you snore loudly? | ☐ Yes | ☐ No |
| Have you been told that you stop breathing at night? | ☐ Yes | ☐ No |
| Are you often tired during the day? | ☐ Yes | ☐ No |
| Is controlling your blood pressure difficult? | ☐ Yes | ☐ No |
| Do you awaken with shortness of breath? | ☐ Yes | ☐ No |
| Do you fall asleep while reading or watching TV? | ☐ Yes | ☐ No |
| Do you ever have trouble concentrating? | ☐ Yes | ☐ No |
| Have you been diagnosed with Sleep Apnea? | ☐ Yes | ☐ No |

☐ I want to learn about how sleep problems affect my health.

☐ I am not interested at this time.

Patient Name: _____ Date: _____

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Order sleep study, titration and treatment if positive for OSA.
Do nothing at this time.

Physician Signature:_____Date: _____