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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: _____

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

Physician Signature:_____Date: _____