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Independent Sleep Diagnostics LLC
Home Sleep Testing Experts

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Please complete this questionnaire to help diagnose your sleep problem.

PATIENT NAME: _____ **Date:** _____

HEIGHT: _____ (ft) _____ (in) **WEIGHT:** _____ (lbs) **BMI:** _____ **NECK SIZE**: _____ (in) **DOB**: ___/___/_____

BRIEFLY DESCRIBE YOUR SLEEP CONCERNS:

_____

DO YOU HAVE A HISTORY OF THE FOLLOWING? CHECK ALL THAT APPLY.

* Snoring
*Witnessed Pauses in Breathing
* Sleepiness
* Headaches
*Depression
*Heart Disease
*Erectile Dysfunction
*Memory Loss
* Choking & Gasping
* Fatigue
* Memory Loss
*High Blood Pressure
*Diabetes
*Other (specify) _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you have a family history of sleep apnea? Yes No

Do you have any lung or breathing problems? Yes No

If yes, please describe. _____

Do you have a Pacemaker? Yes No

Do you use oxygen at night? Yes No

Do you get up to go to the bathroom frequently during the night? Yes No

Have you ever had oral or nasal surgery? Yes No

If yes, please describe. _____

Do you drink alcohol? Yes No

How often? (Circle all that apply)

Daily 3-5 times a week Once a week Only on weekends On special occasions

Any recent change in your intake of alcohol? Yes No

If yes, please describe: _____

PLEASE LIST ALL OF YOUR MEDICATIONS, INCLUDING OVER THE COUNTER:_____

The above information is true and correct to the best of my belief.

Signature _____ Date _____