SLEEP APNEA SCREENING QUESTIONNAIRE

Welcome to the Kaiser Permanente Sleep Apnea Clinic in South San Francisco. This is your first step in a Journey to a Better Sleep. The purpose of this questionnaire is to collect information on your current sleep condition and identify past experience with sleep devices.

Patient's Name: ________________________ **MR#** _______________ **Date:** _____________

1. Do you snore loudly on a regular basis? ☐ Yes ☐ No ☐ Unknown
2. Do you stop breathing or hold your breath when you are asleep? ☐ Yes ☐ No ☐ Unknown
3. Have you been tested for sleep apnea? ☐ Yes ☐ No
   If yes, where and when? ____
4. Are you currently using CPAP or a sleep aid device? ☐ Yes ☐ No
5. Do you use extra oxygen? ☐ Yes ☐ No

6. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired)? Even if some of the following have not affected you recently, try to work out how they did affect or would affect you again.

Use the following scale to choose the most appropriate number for each situation.
0 = No chance of dozing 1 = Slight chance of dozing 2= Moderate chance of dozing 3 = High chance of dozing

Situation	Chance of Dozing			
	0	1	2	3
A) Sitting and reading				
B) Watching TV				
C) Sitting inactive in a public place (e.g. a theater or a meeting)				
D) As a passenger in a car for an hour without a break				
E) Lying down to rest in the afternoon when circumstances permit				
F) Sitting and talking to someone				
G) Sitting quietly after lunch without alcohol				
H) In a car, while stopped for a few minutes in traffic				

Sleep Scale Score: __________