



Northern Nights Sleep Clinic

(...an A.A. Specialty Health Center Clinic)
Obstructive Sleep Apnea Assessment

This questionnaire is a tool to screen for sleep-related breathing problems, or obstructive sleep apnea. It is not a substitute for a sleep disorder evaluation by a qualified physician. However, it can help you identify key factors in your sleep habits that may contribute to obstructive sleep apnea.

If you answer “Yes” to any of these questions, please discuss your symptoms with your health care provider.

- | | | |
|-------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 1. Do you snore or have you been told that you snore? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 2. Have you been told that you appear to hold your breath while asleep? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 3. Do you experience awakenings from sleep with a snort or cough, choking or shortness of breath? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 4. Do your awakenings most often occur when you are sleeping on your back? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 5. Is your sleep disturbed by heartburn, reflux or an acid/sour taste in your mouth? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 6. Do you awaken from sleep with a headache? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 7. Do you avoid sleeping on your back because it is hard to breathe? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 8. Are you currently overweight? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 9. Is your neck size greater than 17 inches if you're a male or greater than 16 inches if you're a female? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 10. Do you frequently awaken with a dry mouth? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 11. Are you excessively sleepy during the day? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 12. Do you fight sleepiness while driving? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 13. Do you have high blood pressure? |



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