LAL BHAGCHANDANI MD PA

Sleep Apnea Questionnaire

(Please check all that applies)

Patient Name: ___________________________

Patient Date of Birth: _____________________

Do you suffer from any of the following?

____Disruptive Snoring	____Excessive daytime sleepiness
____Non restorative sleep	____Disturbed or restless sleep
____Insomnia	____Choking or gasping during sleep
____Nocturia	____Frequent unexplained arousals
____Average Hours of sleep?	____Morning headaches
____Night terrors	____Neck Circumference (size)

Last sleep study and where if any? __________________