Name: ____________________

Date: ____________________

Do I Have Sleep Apnea?

If you have not filled out this form before, please check the symptoms.
If you are experiencing two or more symptoms, please tell your doctor.

	Always	Frequent	Rare
Restless Sleep	☐	☐	☐
Loud, heavy snoring	☐	☐	☐
Daytime sleepiness	☐	☐	☐
Decreased daytime alertness	☐	☐	☐
Irritability, short temper	☐	☐	☐
Morning headaches	☐	☐	☐
Forgetfulness	☐	☐	☐
Mood or behavior changes	☐	☐	☐
Anxiety or depression	☐	☐	☐
Decreased interest in sex	☐	☐	☐