

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loud, heavy snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased daytime alertness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability, short temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood or behavior changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety or depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased interest in sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>