Patient Name _____ ***Date*** _____

Place a checkmark in the box if the statement is true for you!!

I sometimes snore	☐	I sleep sitting up or use more than one pillow	☐
I have been diagnosed with high blood pressure	☐	I sometimes have morning headaches	☐
I have been told that I stop breathing when I sleep	☐	I am on supplemental oxygen	☐
I am overweight or have recently gained weight	☐	I wear a CPAP	☐
I am often tired during the day	☐		

I sometimes get short of breath when...

Walking up stairs	☐	Waking up at night	☐	Walking for one block	☐
When lying down	☐	During daily activities	☐	At rest	☐

Other _____

FOR PHYSICIAN USE ONLY

Resting Oximetry <93%	☐	Diabetes	☐	Cyanosis(Lips/Nailbeds)	☐	Cardiomyopathies	☐
CHF/Dependent Edema	☐	M.O.	☐	COPD	☐	BMI>30	☐

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