SLEEP APNEA QUICKTEST

Question	Answer
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	**YES ___ No ___**
Do you often feel tired, fatigued, or sleepy during the daytime?	**YES ___ No ___**
Has anyone observed you stop breathing during your sleep?	**YES ___ No ___**
Do you have or are you being treated for high blood pressure?	**YES ___ No ___**

Answering yes to two or more questions = High Risk of Obstructive Sleep Apnea

Contact our office today for a free sleep apnea consultation.
Call 1-800-339-4659

For immediate assistance and information please complete the information below and fax this form directly to 1-888-323-9589.

Patient Contact Information		Date:
Name:		Male ____ Female ____ Age: ____
Address:		Email:
City:	Prov. & Postal Code:	Contact Telephone #: __________________

Health History:

Have you previously been diagnosed/tested for sleep apnea? ___ Yes ___ No

If yes, are you currently under treatment? ___ Yes ___ No

Have you had a heart attack? ___ Yes ___ No

Have you had a stroke? ___ Yes ___ No

Do you have diabetes? ___ Yes ___ No

Referred By: ____
Most of our patients are referred by medical doctors. Find out why.

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