9439 Archibald Ave.
Suite 105
Rancho Cucamonga, CA 91730
P: (909) 987-3100
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Patient Questionnaire

Full Name: ______________________________________ Date: ____________________

Cell Phone: _________________ Carrier: _____________ DOB: ____________________
(i.e., Verizon, Sprint, T-Mobile, etc.)

Email: ____

Check the appropriate response

	Question		
1.	Have you been told that you stop breathing while you're sleeping?	Yes □	8
2.	Have you ever fallen asleep or nodded off while driving?	Yes □	6
3.	Do you awaken suddenly with shortness of breath, gasping or with your heart racing?	Yes □	6
4.	Do you feel excessively sleepy during the day?	Yes □	4
5.	Has anyone ever told you that you snore while you're sleeping?	Yes □	4
6.	Have you had a weight gain and found it difficult to lose?	Yes □	2
7.	Have you taken medication for or been diagnosed with high blood pressure?	Yes □	2
8.	Do you kick or jerk you legs while sleeping?	Yes □	3
9.	Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Yes □	3
10.	Do you wake up with headaches during the night or in the morning?	Yes □	3
11.	Do you have trouble falling asleep?	Yes □	4
12.	Do you have trouble staying asleep once you fall asleep?	Yes □	4

Please Add Up Your Total Score: ____________________

0-7 Low	8-11 Moderate	12-15 High	>16 Severe

PATIENT CONSENT

I HEREBY CONSENT TO THE DISCLOSURE OF MY RESPONSES TO THE SLEEP APNEA QUESTIONNAIRE FOR THE PURPOSE OF ASSISTING IN THE DIAGNOSIS AND TREATMENT OF A POTENTIAL SLEEP DISORDER

I UNDERSTAND THAT AS PART OF THIS ORGANIZATION'S TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS, IT MAY BECOME NECESSARY TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO ANOTHER ENTITY, AND I CONSENT SUCH DISCLOSURE FOR THESE PERMITTED USES, INCLUDING, BUT NOT LIMITED TO, DISCLOSURES VIA FAX. I FULLY UNDERSTAND AND ACCEPT THE TERMS OF THIS CONSENT

PATIENT'S SIGNATURE ______________________________________ **DATE** __________________