

**LAKE CITY SURGERY CENTER**  
**OBSTRUCTIVE SLEEP APNEA QUESTIONNAIRE**

<b>Snoring</b>	Do you snore loudly (louder than talking or loud enough to be heard through closed doors).	Yes No
<b>Tiredness</b>	Do you often feel fatigued or sleepy during the day time?	Yes No
<b>Observed Apnea</b>	Has anyone observed you stop breathing during your sleep?	Yes No
<b>Pressure</b>	Do you have or are you being treated for high blood pressure.	Yes No
<b>BMI</b>	Overweight 30 lbs or more	Yes No
<b>Age</b>	> 50 years	Yes No
<b>Neck Circumference</b>	>16 inches	Yes No
<b>Gender</b>	Male	Yes No

\_\_\_\_\_  
 Signature of Patient or Patient Representative

\_\_\_\_\_  
 Date