Phoenix Heart PLLC

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Patient information

For:
Date of Birth:
MRN:

Quality of Sleep Assessment

Please answer the following questions to assist your physician in diagnosing the quality of your sleep:

1. Do you use a CPAP? Yes / No

2. Are you aware that you snore or do others claim you snore? Yes / No

3. Do you feel tired, fatigued, or sleepy during daytime? Yes / No

4. Have you noticed or have others observed that you choke, gasp for air or stop breathing during sleep? Yes / No

5. Do you have high blood pressure? Yes / No

6. Do you consider yourself to be overweight? Yes / No

7. Do you wear a shirt size of large or larger due to small or medium shirts being too tight around the neck? Yes / No

8. Are you male? Yes / No

9. Are you over 50 years of age? Yes / No