



Obstructive Sleep Apnea (OSA) Questionnaire

Patient Information:

Name: _____

Date of Birth: _____

Age: _____

Male / Female

Height: _____ inches/cm

Weight: _____ lbs/kgs

BMI: _____

Neck circumference* _____ cm

Patient Questions:

1. Do you snore loudly enough to be heard in the next room?
2. Do you often feel tired during the day?
3. Has anyone observed that you stop breathing while you sleep?
4. Do you have high blood pressure or are you taking medication for it?
5. Do you have a body-mass index (BMI) greater than 35?
6. Do you have a neck circumference greater than 30 centimeters/15.75 inches?
7. Are you age 50 or older?
8. Are you male?

Patients answering “yes” to three or more of the above questions are at a high risk for OSA and should be referred to a physician.

**Measurements should be taken by dental staff with patient’s consent to ensure accurate baseline.*

Source: American Sleep Apnea Association