Airway Screening Form

Please answer the following questions as they are important in managing your overall health:

1. How many hours, on average, do you sleep each night? _____
2. How many times do you wake up throughout the night? _____
3. Have you ever had dreams of choking or drowning? Yes ____ No ____
4. Do you have difficulty falling or staying asleep? Yes ____ No ____
5. Do you take sleep medication to fall or stay asleep? Yes ____ No ____
6. Do you need coffee or an energy booster to keep you going throughout the day?
   Yes _____ No _____
7. Do you feel tired at any time throughout the day? Yes ____ No ____
8. Do you Snore? Yes ____ No ____
9. Do you suffer from acid reflux or GERD? Yes ____ No ____
10. Do you have high blood pressure or taking medication for it? Yes ____ No ____
11. Have you been diagnosed with Sleep Apnea or advised to have a sleep test?

    Yes _____ No _____