

OBSTRUCTIVE SLEEP APNEA PREOPERATIVE SCREENING TOOL

This questionnaire is a sample tool to screen for obstructive sleep apnea. It is not a substitute for a sleep disorder evaluation by a qualified physician. However, it may help identify at-risk patients during the preoperative period.

Answer YES or NO to each question and place an "X" in the corresponding column.
(To be completed by the patient and his or her bedroom partner.)

Questions	Yes	No
1. Do you snore loudly (e.g., can you be heard through a closed door)?	___	___
2. Does your bedroom partner complain about your snoring?	___	___
3. Does your snoring wake you up at night?	___	___
4. Do you or your bedroom partner notice that you make gasping and choking noises during sleep?	___	___
5. Has your bedroom partner ever noticed that you have stopped breathing during sleep for 10 to 30 seconds?	___	___
6. Do you have a dry mouth, sore throat, or headache in the morning?	___	___
7. Do you often fall asleep during the daytime when you want to stay awake?	___	___
8. Are you often tired during the day?	___	___
9. Have you ever been told that you have obstructive sleep apnea?	___	___

ALERT ANESTHESIA if patient answers YES to any of the above.

References

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