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Questionnaire for Obstructive Sleep Apnea (OSA)

Name: _____ **Date:** _____

Height: _____ inches Weight: _____ lbs

Age: _____ Male/Female Body Mass Index (BMI): _____

Collar size of shirt: S M L XL of _____ inches

Neck Circumference: _____ cm

The **SNAP** test consists of four questions:

1. **Snoring**
   Do you *snore* loudly (louder than talking or loud enough to be heard through closed doors)? Yes No

2. **Tired**
   Do you often feel *tired*, fatigued or sleepy during the day? Yes No

3. **Observed**
   Has anyone observed you stop breathing during your sleep?
   Yes No

4. **Blood Pressure**
   Do you have or are you being treated for high blood *pressure*?
   Yes No

High risk of OSA: answering yes to two or more questions
Low risk of OSA: answering yes to less than two questions

If your score is 2 or greater, call 830-896-4711 for an appointment and bring this questionnaire.

The doctor is in.

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