

Do you experience Daytime Sleepiness	Y	or	N
Experience Impaired Cognition	Y	or	N
Observed Apnea's (Night Awakenings)	Y	or	N
Mood Disorders	Y	or	N
Do you suffer from insomnia	Y	or	N
Do you have Pulmonary Hypertension	Y	or	N
Any Cardiac Disease	Y	or	N
Have you ever had a stroke	Y	or	N
Inappropriate napping	y	or	N
Snoring	Y	or	N
Are you a shift worker	Y	or	N
Family History of Sleep Apnea	Y	or	N
Do you have morning headaches	Y	or	N
Unable to sleep on back	y	or	N
Nighttime bathroom use >2 times or more	Y	or	N
Do you grind your teeth at night	Y	or	N
If any, what Narcotics do you take	_____		