UNITED DIAGNOSTICS

SLEEP STUDIES • VEEG • DME

Sleep Health Disorder Checkup

Have you been told you snore loudly?	❑Yes	❑No
Have you been told that you stop breathing at night?	❑Yes	❑No
Are you often tired during the day?	❑Yes	❑No
Is controlling your blood pressure difficult?	❑Yes	❑No
Do you awaken with shortness of breath?	❑Yes	❑No
Do you fall asleep while reading or watching TV?	❑Yes	❑No
Do you ever have trouble concentrating?	❑Yes	❑No
Have you been diagnosed with Sleep Apnea?	❑Yes	❑No

❑ **I want to learn about how sleep problems affect my health**

❑ **Do not contact me.**

Name:_____e-mail:_____ Contact #:_____

Physician Use Only:

❑**Reviewed, order sleep study, titration and treatment if positive for OSA.**

FAX to (888) 539-3001

❑**Reviewed, do not order sleep study; place in chart.**

Physician Signature: _____ Date: _____