Graduated Apnea Screening Protocol (GASP)
Questionnaire for Sleep Evaluation

Name: _____

Address: _____

Height: _____ Weight: _____

Age: _____ Sex: _____

Questions:	
Have you been told (or noticed on your own) that you snore most nights?	Yes No Not Sure
Have you been told that you stop breathing or struggle to breathe in your sleep?	Yes No Not Sure
Are you tired, fatigued or sleepy most days?	Yes No Not Sure
Do you have acid indigestion or high blood pressure (or use medication to control any of these conditions)?	Yes No Not Sure
Are you overweight?	Yes No Not Sure

Your Score: 0

OSA Risk

Score of: 4 or higher = high risk
3 = moderate risk
2 or less = lower risk