OSMI
www.sleepmedicine.com

OHIO SLEEP MEDICINE INSTITUTE
CENTER OF SLEEP MEDICINE EXCELLENCE™

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Graduated Apnea Screening Protocol (GASP) Questionnaire
Sleep Evaluation

Name _____
Address_____
Height _____ Weight _____
Age _____ Male / Female _____

1. FILL OUT QUESTIONNAIRE

Score=	1	0	1
Have you been told (or noticed on your own) that you snore on 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 on 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
SCORE			

2. ADD ALL THREE COLUMNS TOGETHER

_____

3. CALCULATE OSA RISK

4 or higher = high risk for OSA
3 = moderate risk for OSA
2 or less = lower risk for OSA