Obstructive Sleep Apnea (OSA) is the "TRUE SILENT KILLER"

The "**HEART SAFE**" Questionnaire

**Sleep Awareness Favors Effective Outcomes**

Questionnaire

Name_____ Date_____

This questionnaire is a simple outline to improve OSA screening, optimize continuity of care and patients' overall health status outcomes (prevention of Coronary Artery Disease, Sudden Cardiac Death, Arrhythmias, Hypertension and Stroke).

**Do you have heart disease?** _____ Yes _____ No _____ Not Sure

1. **Do you have risk factors for heart disease (Please check all that applies to you)?**

- ○ Family History (any immediately family or first-degree relatives have had a heart attack, heart stent , CABG/bypass heart surgery, sudden cardiac arrest/death, heart transplant, peripheral vascular disease before the age of 55.
- ○ Age (male >45 years of age, female >55 years of age)
- ○ Gender: ___ Male ___Female
- ○ Hypertension (High Blood Pressure)
- ○ Diabetes __Type I __Type II
- ○ Smoking
- ○ Hypercholesterolemia (High Cholesterol)
- ○ Obesity

1. **Do you experience chest pain or discomfort (which may also mean: pressure, tightness, ache, heaviness, fatigue or shortness of breath)? If YES, then indicate symptoms.**

_____ No _____ Yes _____

2. **Have you experienced a stroke?**

_____ No _____ Yes If yes: Date_____

3. **Do you have a history of heart failure?**

_____ Yes _____ No _____ Not Sure if yes, Have you been admitted for heart failure? _____ Yes _____ No

4. **Have you been readmitted for heart failure within 30 days after discharge?**

_____ Yes _____ No

5. **Are you aware of your heart function, your ejection fraction (EF)?**

_____No _____ Yes If yes, what is your EF _____%

**Do you have an implanted cardiac device?** _____ Yes _____ No Date of Implant _____

- ○ Pacemaker
- ○ Defibrillator
- ○ Loop Recorder
- ○ Unsure

## ARRHYTHMIA HISTORY

9. **Have you experienced an irregular heart beat or fluttering? Do you have PALPITATIONS (another term reflective of an "irregular" heart beat or rhythm)?**

   _____No _____Yes (If yes, please explain your symptoms) _____

10. **Have you experienced or recorded (via Apple Watch, Fitbit etc.) a slow heart rate while awake or during sleep? Less than 60 beats per minute is considered slow heart rate.**

    _____ Yes _____ No

11. **Have you experienced or recorded a fast heart rate while awake or during sleep? Greater than 100 beats per minute is considered a fast heart rate.**

    _____ Yes _____ No

12. **Have you had to undergo an ABLATION FOR AN ARRHYTHMIA? If yes, then for which abnormal rhythm?**

    _____No _____ Yes (If yes what was the abnormal rhythm? _____)

Print Name_____ Signature_____