

Sleep Apnea Symptom Tracker

Name: _____

Week Starting: _____

SYMPTOM / METRIC	MON	TUE	WED	THU	FRI	SAT	SUN
Hours Slept							
Snoring Severity (1-5)							
Waking Gasping/Choking							
Morning Headache							
Daytime Sleepiness (1-5)							
Dry Mouth/Sore Throat							
Irritability/Mood							
CPAP Used? (Y/N)							

Scale: 1 = Mild / None 5 = Severe / Constant Checklist: “ = Yes

WEEKLY OBSERVATIONS & NOTES: