SNORING AND SLEEP APNEA QUESTIONNAIRE

NAME _____ DATE _____
AGE _____ MALE _____ FEMALE _____ WEIGHT _____

Please answer the following questions by indicating frequency

Daily	Every or almost every night or day
Often	At least once or twice per week
Infrequently	Less than once a week
Never	

During your usual sleep, have you noticed or have you been told that you do the following (check one answer in each category)?

	Daily	*Often*	*Infreq.*	*Never*
Snore loudly	_____	_____	_____	_____
Choke, struggle for breath or stop breathing	_____	_____	_____	_____
Awaken repeatedly because of a breathing problem	_____	_____	_____	_____
Toss and turn frequently	_____	_____	_____	_____
Kick or jerk legs repeatedly	_____	_____	_____	_____

When you wake up after your usual sleep, how often do you experience the following?

Headache	_____	_____	_____	_____
Dry Mouth	_____	_____	_____	_____
Feel tired or unrested	_____	_____	_____	_____

During the time when you are usually awake (daytime and evening), how often do you become irresistibly sleepy or do you fall asleep in the following circumstances?

After a meal	_____	_____	_____	_____
Reading or watching T.V.	_____	_____	_____	_____
At church or school	_____	_____	_____	_____
At work	_____	_____	_____	_____
While a passenger in a vehicle	_____	_____	_____	_____
While driving a vehicle	_____	_____	_____	_____

Do you have trouble breathing through your nose?

Daytime	_____	_____	_____	_____
Nighttime, in bed	_____	_____	_____	_____

Do you consume an alcoholic beverage or take sedatives?

Daytime	_____	_____	_____	_____
Nighttime	_____	_____	_____	_____

Have you had or used any of the following?

Broken nose	Y	N	Nose surgery	Y	N	Tonsillectomy	Y	N
Hay fever	Y	N	Sinus problems	Y	N	Antihistamines	Y	N
Cigarettes	Y	N	Nasal sprays	Y	N	Prev. treatment	Y	N

Do you take medications for any of the following?

Heart condition	Y	N	Respiratory condition	Y	N
Thyroid condition	Y	N	Metabolism (weight)	Y	N

1. How long have you been aware of your snoring? _____
2. Has it caused problems for relatives/friends? _____

3. Have you been told your breathing stops while asleep? _____

4. Have you been told you move around a lot while asleep? _____

5. What position do you sleep in? Side _____ Back _____ Stomach _____

6. About how many times per night do you wake up? _____

7. Do you have any difficulty falling asleep at night? _____

8. How many hours of sleep per night do you get? _____

9. Do you most often wake up feeling refreshed? _____

10. Do you often wake up with a headache? _____

11. Does a small amount of alcohol give you a headache? _____

12. Do you feel sleepy during the day?

    Frequently _____ Occasionally _____ Seldom or Never _____

13. What other doctors have you seen about snoring or sleep apnea? _____

    _____

14. Have you had a sleep lab study? _____

15. Do you have difficulty breathing through your nose? _____

16. Have you gained weight recently? _____ How much? _____

17. Present weight? _____ Height? _____

18. Do you know if you have any heart irregularities? _____

    _____

19. Do you have high blood pressure? _____ What is yours? _____

20. Do you have any loss of memory? _____ Depression? _____

21. Do your jaw joints click? _____ Hurt? _____ Lock? _____

_____ _____

PATIENT **DATE**