SLEEP APNEA AND/OR SNORING QUESTIONNAIRE

Name _____ Date _____

1. How long have you been aware of your snoring ? _____
2. Has it caused problems for relatives or friends? _____
3. Have you been told your breathing stops while asleep? _____
4. Have you been told you move around a lot while asleep? _____
5. About how many times per night do you wake up? _____
6. Do you have any difficulty falling asleep at night? _____
7. How many hours of sleep do you get per night? _____
8. Do you most often wake up feeling refreshed? _____
9. Do you often wake up with a headache? _____
10. Will a small amount of alcohol give you a hangover? _____
11. Do you feel sleepy during the day frequently? _____ occasionally _____ seldom or never ____
12. What other Doctors have you seen about your snoring or sleep apnea? _____
13. Have you had a sleep lab study? _____
14. Do you have difficulty breathing through your nose? _____
15. Have you gained weight recently _____ About how much? _____
16. Present body weight _____ height _____ft. _____ inches
17. What professional advise or treatment have you received about your snoring or sleep apnea? _____

_____

_____ _____

Signature Date