

Questionnaire for Sleep Apnea and/or Snoring

(Use back if more space is needed)

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 per night do you get? _____
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 never
12. What other doctors have you seen about your snoring or sleep apnea? _____
13. Have you had a sleep lab study? Yes No
14. Do you have difficulty breathing through your nose? Yes No
15. Have you gained weight recently? Yes No
About how much? _____
16. Present body weight: _____ height: _____ ft. _____ inches
17. What professional advice or treatment have you received about your snoring or sleep apnea?

Signature: _____ Date: _____