Questionnaire for Sleep Apnea and/or Snoring

Name:_____

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?(circle one) 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?_____
14. Do you have difficulty breathing through your nose?_____
15. Have you gained weight recently?_____

    If so, how much?_____
16. Present body weight:_____
17. What professional advice or treatment have you received about your snoring or sleep apnea?_____

Signature:_____ Date:_____