

# Snoring and Sleep Apnea Questionnaire

In attempt to learn more about you and your snoring or sleep apnea, please complete this questionnaire with the assistance from your spouse or bed partner.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Height (inches): \_\_\_\_\_ Weight (lbs): \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status    Single    Married    Divorced    Separated    Widowed    Domestic Partner

Is there usually a bed partner to observe your sleep? \_\_\_\_\_

Snoring Intensity (if you have a bed partner please him/her circle the intensity):

(Barely Audible) 0   1   2   3   4   5   6   7   8   9   10 (Loud Snoring Heard from Another Room)

## Snoring History

How long have you been aware of your snoring? \_\_\_\_\_

How serious a problem is it for you/spouse/bed partner?    **Mild**    **Moderate**    **Severe**

Have you seen a specialist for this problem before?    **Yes**    **No**

If so, what treatment have you undergone? \_\_\_\_\_

	<b>Always</b>	<b>Sometimes</b>	<b>Never</b>
Have you snored or have you been told that you do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has it caused problems for family or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been told your breathing stops while asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you awake suddenly gasping/choking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been told you move around a ot while asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel well rested in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel tired during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble breathing through your nose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you most often wake up feeling refreshed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you often wake up with a headache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Additional Comments:**