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## Questionnaire for Sleep Apnea and/or Snoring

(Use back if more space is needed)

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

1. How long you have 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  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
16. About how much? \_\_\_\_\_
17. Present body weight: \_\_\_\_\_ height: \_\_\_\_\_ feet \_\_\_\_\_ inches
18. What professional advice or treatment have you received about snoring or sleep apnea?

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_