Questionnaire for Sleep Apnea and / or Snoring

Name: _____ **Date:**_____

1. How long have you been aware of your snoring? _____

2. Has it caused problems fro 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 an Hangover?

11. Do you feel sleepy during the day? ☐ **Frequently** ☐ **Occasionally** ☐ **Seldom** ☐ **Never**

12. What other doctors have seen about your snoring or Sleep apnea? _____

13. Have you had a sleep 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 advice or treatment have you received about your snoring or sleep apnea?

Signature: _____ **Date:** _____