



Snoring Questionnaire

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Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: **M** **F**

Height: _____ Weight: _____ Neck (collar) size: _____ BMI: _____

Medical History

	Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>

Past Surgical History (please include approximate dates of surgery)

	Yes	No	Date
Adenoidectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>	
LAUP	<input type="checkbox"/>	<input type="checkbox"/>	
Uvuloplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Nasal Septal Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Maxillofacial	<input type="checkbox"/>	<input type="checkbox"/>	
Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	

	Yes	No	How Much
Gained weight recently?	<input type="checkbox"/>	<input type="checkbox"/>	
Lost weight recently?	<input type="checkbox"/>	<input type="checkbox"/>	

Do you exercise? Never Rarely Occasionally Frequently Daily

	Yes	No
Ever been diagnosed with sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a polysomnogram?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, it is important to bring a copy of this test to your appointment.

Have you ever used (circle) C-PAP Bi-PAP How long? _____

Name: _____ Date of Birth : _____ Date: _____

Evaluation of snoring as reported by bed partner (please check one):

- 1 2 3 4 5 6 7 8 9 10

- 0 – 3 Occasional soft snoring; not bothersome to bed partner
- 4 – 6 Persistent snoring; bothersome to bed partner
- 7 – 9 Persistent loud snoring; frequently annoying bed partner
- 10 Heroic snoring; continuous, loud snoring not tolerated by bed partner

How often do you fall asleep or fight the urge to fall asleep while driving?

- Seldom Sometimes Often Must pull off the road

Have you ever been evicted from your bed or bedroom?	Yes	No
Has your companion ever moved to another room?	Yes	No
Are you able to share a hotel room with a travel companion?	Yes	No
Do you snore while sleeping on your back?	Yes	No
Do you snore while sleeping on your stomach?	Yes	No
Do you snore while sleeping on your side?	Yes	No
Do you have any difficulty waking up in the morning?	Yes	No
Do you have any difficulty staying awake during the day?	Yes	No
Do you have any difficulty with your memory?	Yes	No
Do you have any difficulty breathing through your nose?	Yes	No
Do you have any difficulties with mouth breathing at night (i.e. dry mouth in the morning)?	Yes	No
Do you have excessive movements during sleep?	Yes	No
Do you wake up during the night grasping for air?	Yes	No
Do you awaken during the night with your heart pounding?	Yes	No
Have you had any problems with narcolepsy (falling asleep involuntarily during the day)?	Yes	No
Any observed periods at night when you stop breathing?	Yes	No

Comments or other information not included above?

I have reviewed the above information with the patient.

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