

### SNORING AND SLEEP APNEA QUESTIONNAIRE

Answering the following questions will assist with your evaluation. We appreciate your assistance.

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

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

1. Do you snore? Yes No
2. Do you awaken feeling tired, fatigued, in want of a "good nights sleep?" Yes No
3. Does your sleep partner report periods where you appear to stop breathing or choking while you are sleeping Yes No
4. Has your sleep partner moved out of your room because of your snoring? Yes No
5. Do you experience leg jerks/restless legs? Yes No
6. Do you awaken with a headache? Yes No
7. Are you often irritable from lack of sleep? Yes No
8. Do you find you fall asleep easily while at meetings or when driving? Yes No
9. Do you experience difficulty concentrating? Yes No
10. Do you have difficulty with forgetfulness? Yes No
11. Have you been diagnosed with depression or seeking help from a therapist? Yes No
12. Do you smoke cigarettes? Yes No
13. How much alcohol do you drink in the evening? \_\_\_\_\_
14. Do you use caffeine after 4:00 p.m.? Yes No
15. How tall are you? \_\_\_\_\_ How much do you weigh? \_\_\_\_\_
16. Have you gained weight recently? \_\_\_\_\_ Yes No If so, how much? \_\_\_\_\_
17. Do you have high blood pressure? Yes No
18. Are your nasal passages obstructed? Yes No
19. Have you ever had nasal surgery? Yes No
20. Have you ever had hayfever or allergic rhinitis? Yes No
21. Have you ever had nasal polyps? Yes No
22. Have you ever had hypothyroidism (low thyroid)? Yes No
23. Have you had a sleep study done? Yes No  
If so, when? \_\_\_\_\_ Where? \_\_\_\_\_
24. Have you ever used C-PAP (a mask to aid with breathing while sleeping)? Yes No  
Was it effective? \_\_\_\_\_