

## SNORING/SLEEP APNEA QUESTIONNAIRE

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

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  Male  Female

Height: \_\_\_\_' \_\_\_\_" Weight: \_\_\_\_\_ lb

Please answer each of the following questions as completely as you can. These questions will help us evaluate the degree of your snoring problem and the success of your treatment.

1. How bad do you rate your snoring?  
 Not a problem  Not bad  Bad  Very bad  Extremely bad
2. How bad do other people rate your snoring?  
 Not a problem  Not bad  Bad  Very bad  Extremely bad
3. Is your snoring getting worse?  Yes  No
4. Does your spouse sleep in the same room that you do?  Yes  No
5. Does your spouse wear ear plugs to bed?  Yes  No
6. Do you fall asleep easily?  Yes  No
7. Do you fall asleep while driving?  Yes  No
8. Can people hear you snore in the next room?  Yes  No
9. Do you ever wake up choking?  Yes  No
10. Do you wake yourself up with your own snoring?  Yes  No
11. Do you fall asleep at work?  Yes  No

12. Have you ever been diagnosed with sleep apnea?

O Yes    When? \_\_\_\_\_  
            By Whom? \_\_\_\_\_  
            How were you treated? \_\_\_\_\_  
            \_\_\_\_\_

O No

13. Have you ever been treated for sleep apnea?

O Yes    When? \_\_\_\_\_  
            By Whom? \_\_\_\_\_  
            Where? \_\_\_\_\_  
            How were you treated? \_\_\_\_\_  
            \_\_\_\_\_

O No

14. Have you ever been treated for snoring?

O Yes    When? \_\_\_\_\_  
            By Whom? \_\_\_\_\_  
            Where? \_\_\_\_\_  
            How were you treated? \_\_\_\_\_  
            \_\_\_\_\_

O No

15. If you have ever been treated for snoring, has the snoring recurred?    O Yes    O No

16. Has anyone told you that you stop breathing while you are asleep?    O Yes    O No

17. Are you tired in the morning when you wake up?    O Yes    O No

18. Do you have morning headaches when you wake up?    O Yes    O No

19. Can you breathe through your nose?    O Yes    O No

20. Do you have allergies or hay fever?    O Yes    O No

21. Have you ever had a broken nose or nasal surgery?    O Yes    O No

22. Are you sleepy during the day?    O Yes    O No

23. Past medical history. Do you have any of the following?

High blood pressure  Yes  No

Heart disease  Yes  No

Heart attack  Yes  No

Irregular heart beat  Yes  No

Heart surgery  Yes  No

Diabetes  Yes  No

Lung disease  Yes  No

Thyroid disease  Yes  No

Bleeding tendencies  Yes  No

Cancer  Yes  No

Please explain: \_\_\_\_\_

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24. Have you had any previous surgeries? Please list with approximate dates:

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25. Do you have any drug allergies?

Yes Please list: \_\_\_\_\_

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No