



SNORING QUESTIONNAIRE

Name: _____ Date: _____

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

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

Medical History

Asthma Yes No Irregular heart beat Yes No

Diabetes Yes No Sinusitis Yes No

Heart failure Yes No Sleep apnea Yes No

Hypertension Yes No Thyroid Disease Yes No

Past Surgical History *(please include approximate dates of surgery)*

Adenoidectomy _____ Nasal Septal Surgery _____

Tonsillectomy _____ Sinus Surgery _____

LAUP _____ Maxillofacial _____

Uvulopalatoplasty (UPP) _____ Tracheostomy _____

Gained weight recently? Yes No How much? _____

Lost weight recently? Yes No How much? _____

Do you exercise? Never Rarely Occasionally Frequently Daily

Ever been diagnosed with sleep apnea? Yes No

Ever had a polysomnogram (sleep study)? Yes No

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? _____

Evaluation of snoring as reported by bed partner (*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 <i>back</i> ?	Yes	No
<i>stomach</i> ?	Yes	No
<i>side</i> ?	Yes	No
Difficulty waking up in the morning?	Yes	No
Difficulty staying awake during the day?	Yes	No
Difficulty with your memory?	Yes	No
Difficulty breathing through your nose?	Yes	No
Mouth breathing at night (dry mouth in the morning)?	Yes	No
Excessive movements during sleep?	Yes	No
Wake up during the night with your heart pounding?	Yes	No
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.

_____ Date:: _____