SNORING PATIENT QUESTIONNAIRE

Name: Last_____ First_____ MI _____

Height: _____ ft_____ in Weight: _____ lbs. Shirt collar size: _____

Language(s) routinely spoken: (list in order of most used to least used) _____

Who referred you to this office? (Circle) Self Spouse Mate Parent(s) Child (ren) Friend(s) Advertisement

Physician (specify) _____ Other_____

USE THE FOLLOWING SCALE TO CHOOSE THE MOST APPROPRIATE NUMBER FOR EACH SITUATION:

0 = would ***never*** doze
1 = ***Slight*** chance of dozing
2 = ***Moderate*** chance of dozing
3 = ***High*** chance of dozing

Situation	Chance of dozing	Situation	Chance of dozing
Sitting and reading		Lying down in the afternoon	
Watching TV		Sitting and talking to someone	
Sitting, inactive in public		Sitting quietly after lunch(no alcohol)	
Car passenger (for an hour)		Stopped for a few minutes in traffic	

CIRCLE THE APPROPRIATE RESPONSE

How long have you had a snoring problem? Less than 5 yrs More than 5 yrs More than 10 yrs
This problem (snoring) started: Suddenly Gradually Intermittently
Do you snore every night? Yes No
How many hours of sleep do you get at night? _____
Do you feel rested in the mornings? Yes No
How many pillows do you use? _____
Rate the effect of your problem on your PERSONAL LIFE No effect Mild Moderate Severe
Rate the effect of your problem on JOB PERFORMANCE No effect Mild Moderate Severe
What is the loudness of your snoring? Mild Moderate Severe
How bothersome is this to your mate? Mild Moderate Severe
Do you play a wind instrument? Yes No
Are you a vocal performer? Yes No
If yes circle the category which best applies to you Singer / Actor / Public Speaker
Clergy / Other (specify) _____
How motivated are you to alleviate the problem? Mildly / Somewhat / Very
Have you ever been diagnosed with "SLEEP APNEA"?
If yes – Where? (Clinic/Institution name) _____
Physician's Name who treated you _____
Was a "Sleep Study" done? Yes / No If "Yes" – where? _____
Have you been TREATED for Sleep Apnea? Yes / No
If "Yes" – describe the treatments _____
How effective was the treatment? No Improvement / Mild Improvement/ Good Improvement

Clinical Information & Symptoms: Circle which ones relate to you

Daytime drowsiness	Morning headaches	Occasional bed wetting	Witnessed Apnea event	Gasping/choking	Fall asleep while driving	Difficulty waking up	Tire quickly
Loud/ disruptive snoring	Irritability/ Moodiness	Hypertension	Restless leg	Dizziness/ loss of balance	Fall asleep at work	Poor memory	Insomnia
Difficulty staying asleep	Difficulty falling asleep	Difficulty concentrating	Numbness or tingling of fingers	None of the above			