# 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 | *back*? | Yes | No |
| | *stomach*? | Yes | No |
| | *side*? | 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 though 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::____________________