Sleep Apnea/Snoring Questionnaire

Name_____ Date_____

1. How long have you been aware of your snoring?_____
2. Has it caused problems for relatives or friends?_____
3. Have you been told your breathing stops while sleeping?_____
4. Have you been told you move around a lot while you sleep?_____
5. About how many times per night do you wake up?_____
6. Do you have any difficulty falling asleep?_____
7. How many hours of sleep do you get?_____
8. Do you most often wake up with a headache?_____
9. Do you often wake up with a headache?_____
10. Will a small amount of alcohol give you a headache?_____
11. Do you frequently feel sleepy during the day?_____
12. What other doctors have you seen about your snoring or sleep apnea?

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13. Have you ever had a sleep lab study?_____
14. So you have difficulty breathing through your nose?_____
15. Have you gained weight recently?_____
16. Present body weight_____ Height_____
17. What professional advice or treatment have you received about your snoring or sleep apnea?_____

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