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

CIRCLE THE SYMPTOMS BELOW WHICH YOU FREQUENTLY HAVE

day time drowsiness	morning headaches	occasional bed wetting
fall asleep while driving	difficulty waking up	tire quickly
dizziness / loss of balance	fall asleep at work	poor memory
difficulty staying asleep	difficulty falling asleep	difficulty concentrating
numbness of tingling of fingers	none of the above	