Snoring and Sleep Apnea Questionaire

Name _____ Date _____

Clinical Information (Check all that apply)

☐	Disruptive snoring	☐	Witnessed apnea during sleep
☐	Disturbed or restless sleep	☐	Frequent unexpected arousals from sleep
☐	Non-restorative sleep	☐	Regular sedative / sleep-aid use
☐	Regular alcohol use	☐	Choking / gasping during sleep
☐	Excessive daytime sleepiness	☐	Excessive daytime fatigue

What is your Snore Score? Snoring can be a harmless annoyance or an indication of a more serious sleep disorder. This short quiz can help determine if you may need further evaluation for a sleep condition. *A score of 5 or higher is associated with sleep-disordered breathing.*

Use the following scale to choose the most appropriate number that describes the snoring in your situation:

0 = **Never**
1 = **Infrequently** (1 night per week)
2 = **Frequently** (2-3 nights per week)
3 = **Most of the time** (4 or more nights per week)

Snoring affects my relationship with my partner	
Snoring causes my partner to be irritable or tired	
Snoring requires us to sleep in separate rooms	
The snoring is loud	
Snoring affects other people when I sleep away from home (e.g. hotel)	
TOTAL	

Physician Signature: _____ Date _____