SLEEP DISORDER QUESTIONAIRE

Name_______________________________Date_____________
Height______Weight_______Neck Size___________
1) How long have you been snoring?____
2) How much of a problem is it for you?______________________________________
3) Is it a problem for anyone else?____
4) In what body position(s) do you snore?____________________________________
5) Have you tried any treatment for it? yes / no If yes, what have you tried?________
____
____
6) Have you had a sleep study? yes / no If so, when was it and what did it show?_____
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7) Check any of the following that pertain to you?

__taking medication for allergy, sleep, pain, depression, or anxiety
__smoke tobacco. Amount per day________
__drink alcohol.   Amount per day________
__take sleeping pills
__tonsillectomy
__tracheotomy
__nasal &/or sinus surgery
__ other surgery for snoring or sleep apnea
__heart surgery
__partner sleeps in another room
__weight gain (how much in the past year_____)
__congested nose
__snore every night
__high blood pressure
__irregular heart beat
__heart failure
__wake-up gasping for breath
__stop breathing during sleep
__tired all the time
__thyroid disease
__sleep apnea
__restless disturbed sleep
__headaches upon awakening
__falling asleep during the day or after meals
__feet kick and jerk during sleep
__stop breathing during sleep
__impotence
__indigestion or heartburn
__sing and/or play a wind instrument

9) Any other snoring related problems that bother you or you are concerned about?___
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