

Please print this form and answer the following questions.

SLEEP – SNORING QUESTIONNAIRE

Patient's name _____

Patient's SSN _____

Gender: Male Female

To answer: Circle **Yes** or No:

- Yes No My family / friends complain about my snoring.
- Yes No People refuse to share a bedroom because of my snoring.
- Yes No Experience loud snoring when sleeping on my back.
- Yes No Experience loud snoring when sleeping on my side.
- Yes No Experience loud snoring even when asleep sitting up.
- Yes No I have been told I stop breathing during sleep.
- Yes No I have been told I choke or gasp during sleep.
- Yes No I wake up with a choking or gasping sensation.
- Yes No I wake up with my heart beating faster than usual.
- Yes No Experience nasal congestion, obstruction, or discharge at night.
- Yes No Dry mouth upon awakening.
- Yes No Headaches upon awakening.
- Yes No Wake up feeling tired.
- Yes No Feel exhausted despite sleeping for many hours.
- Yes No Fight sleepiness during daily activities.
- Yes No Difficulty staying alert when I am required to.
- Yes No Decreased concentration.
- Yes No Forgetfulness.
- Yes No Taking more than 30 minutes to fall asleep on most nights.
- Yes No Waking up during the night and having a hard time falling back asleep.
- Yes No Waking up early and being unable to fall back asleep.
- Yes No Need to use sleep aids.
- Yes No Unable to sleep at all.
- Yes No "Restlessness of legs" when lying down in bed before sleep.
- Yes No Leg twitches during sleep.