SNORING QUESTIONNAIRE

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PATIENT NAME (PLEASE PRINT)		PATIENT DATE OF BIRTH	
HEIGHT	WEIGHT	AGE	☐ MALE ☐ FEMALE

Please choose the correct response to each question:

CATEGORY 1

1. Do you snore?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

<u>If you snore:</u>

2. Your snoring is:
   - ☐ Slightly louder than breathing
   - ☐ As loud as talking
   - ☐ Louder than talking
   - ☐ Very loud—can be heard in adjacent rooms

3. How often do you snore
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or rarely

4. Has your snoring ever bothered other people?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

5. Has anyone noticed that you stop breathing during your sleep?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

CATEGORY 2

6. How often do you feel tired or fatigued after your sleep?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or rarely

7. During your waking time, do you feel tired, fatigued or not up to par?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or rarely

8. Have you ever nodded off or fallen asleep while driving a vehicle?
   - ☐ Yes
   - ☐ No

<u>If yes:</u>

9. How often does this occur?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

CATEGORY 3

10. Do you have high blood pressure?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

*****THANK YOU!*****