

HEAD AND NECK SURGERY ASSOCIATES

SNORING / SLEEP APNEA QUESTIONNAIRE

Name: _____ Date: _____

When was your snoring first noticed?	Never	(Approximate date)	Mo.	Year
When was your sleep apnea first noticed?	Never	(Approximate date)	Mo.	Year
Do you have difficulty waking up in the morning?	No	Yes		
Do you have difficulty staying awake during the day?	No	Yes		
Do you have difficulty staying awake while driving?	No	Yes		
Do you have difficulty breathing through your nose?	No	Yes	Right side	Left side
Do you mouth breathe at night?	No	Yes		
Do you wake up during the night gasping for air?	No	Yes		
Has anyone ever observed that you stop breathing for periods of time during the night?	No	Yes		
Have you had a sleep study?	No	Yes		
If "Yes" When: _____ Where: _____				
Have you used: CPAP?	No	Yes		
Have you used BIPAP?	No	Yes		
If "Yes" how long did you use it? # _____ days weeks months years				
Are you currently using the machine?	No	Yes		
Are you happy with the machine and the results?	No	Yes		
Were you ever diagnosed with Sleep apnea?	No	Yes		
If "Yes" when? Date: _____				
By whom? _____				
Have you ever had any nose surgery?	No	Yes	on _____ by whom? _____	
Have you ever had any throat surgery?	No	Yes	on _____ by whom? _____	
Have you ever had any sinus surgery?	No	Yes	on _____ by whom? _____	
Do you snore while on your	Back	Stomach	Side	All positions
Do you exercise?	Never	Rarely	Occasionally	Frequently Daily
Have you ever been evicted from your bed or bedroom?	No	Yes		
Has your bedpartner ever moved to another room?	No	Yes		
Are you able to share a hotel room with a travel companion?	No	Yes		
Bedpartner reports snoring on a scale of 1-10 (CIRCLE ONE)	0-3 occasional soft snoring			
	4-6 persistent snoring			
	7-9 persistent loud snoring			
	10 heroic snoring - not tolerable to bedpartner			
MEN: What is your neck size?				

Comments or other information not included above?

