

## Sleep Apnea and Snoring Questionnaire

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

What is your main motivation in seeking our help?

\_\_\_\_\_ spouse or roommate noise complaints      \_\_\_\_\_ bed partner losing sleep due to your snoring  
 \_\_\_\_\_ spouse worry about your breathing      \_\_\_\_\_ your health worry  
 \_\_\_\_\_ dry mouth      \_\_\_\_\_ daytime sleepiness  
 \_\_\_\_\_ poor sleep      Other \_\_\_\_\_

What is your present weight: \_\_\_\_\_ Present Height \_\_\_\_\_ ft. \_\_\_\_\_ in.

Have you gained weight recently? \_\_\_\_\_

Approximately how much? \_\_\_\_\_

### Snoring:

How long have you been aware of your snoring? \_\_\_\_\_

Has it caused problems for friends and/or relatives? Yes No

Have you been told your breathing stops while asleep? Yes No

Do you have difficulty breathing through your nose? Yes No

Do you snore in all positions or only on back \_\_\_\_\_

### Sleep:

• Do you have any difficulty falling asleep at night? Yes No

• Have you had any of the following:

○ Frequent urination \_\_\_\_\_ How many times? \_\_\_\_\_

○ Excessive Thirst \_\_\_\_\_

• Approximately how many times per night do you wake up? \_\_\_\_\_

• Do you wake up gasping or choking? Yes No

• Do you wake up feeling unrefreshed? Yes No

• How many hours of sleep per night do you get? \_\_\_\_\_

• How many hours do you feel you need? \_\_\_\_\_

### Daytime Drowsiness:

Do you wake up feeling unrefreshed? Yes No

• Any effects on daily activity? \_\_\_\_\_

• Any cognitive impairment? \_\_\_\_\_

Has there been deterioration in your job performance? Yes No

Do you feel sleepy during the day:

Frequently \_\_\_\_\_ Occasionally \_\_\_\_\_ Seldom/Never \_\_\_\_\_ While driving a car \_\_\_\_\_

What is your caffeine intake? \_\_\_\_\_

**Additional Information:**

Do you often wake up with a headache?	Yes	No
Do you know you have any heart irregularities?	Yes	No
Do you have high blood pressure? Yes No What is your BP? _____		
Do you have any loss of memory?	Yes	No
Do you suffer from depression?	Yes	No
Have you had a lab sleep study?	Yes	No

When? \_\_\_\_\_ Name of Doctor: \_\_\_\_\_

What professional advice or treatment have you received about your snoring or sleep apnea?

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**Daily Physical Activities:**

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**Dental History:**

Name of dentist: \_\_\_\_\_

Last dental visit: \_\_\_\_\_

History of joint problems/TMJ:

Click \_\_\_\_\_

Stick \_\_\_\_\_

Hurt \_\_\_\_\_

History of periodontal disease/problem: \_\_\_\_\_

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Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_