ENT Ear, Nose & Throat *Specialty Care*

Administrative Office: 2211 Park Avenue South | Minneapolis, Minnesota 55404 | Tel. 612.871.1144 | Fax 612.871.2012

SNORING QUESTIONNAIRE

NAME: _____**Date of Birth**_____ **DATE:** _____

Please answer the following questions as best as you can. This information is essential to properly assess your snoring problem and to help us develop a treatment plan for you.

I. General Information

1. How long have you been snoring? _____
2. Do you snore every night or just occasionally? *(circle)*
3. Is snoring getting worse? YES NO
4. Do you snore loudly at night? YES NO
5. Do you wake yourself up? YES NO
6. Do you have restless disturbed sleep? YES NO
7. Does your bed partner move out of the room because of your snoring? YES NO
8. Do you ever stop breathing during your sleep? YES NO
9. How long are the pauses? _____
10. Are the pauses frequent? YES NO
11. How long has this been happening? _____
12. Have you ever had a sleep study or been evaluated for sleep apnea? YES NO

    a. Which Hospital and when? _____
13. Have you ever tried any snoring devices? YES NO
14. *Which ones?* _____

II. Daytime Symptoms - Are you tired no matter how much you sleep? YES NO

1. Do you often wake up in the morning with a headache? YES NO
2. Are you drowsy or sleepy during the day? YES NO
3. Does daytime sleepiness interfere with your work? YES NO
4. Have you ever fallen asleep while driving or eating? YES NO
5. How many naps do you take during the day? YES NO
6. Do you easily fall asleep in quiet places? YES NO
7. Do you drink coffee, tea, cola or take caffeine to stay awake? YES NO
8. Is your sleep/snoring problem causing emotional problems? YES NO
9. Do you work varying shifts at work such that your sleep pattern is irregular? YES NO

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III. Medical History

1.	How much do you weigh? _____		
2.	How much did you weigh five years ago? _____		
3.	Do you have nasal allergies or hay fever?	YES	NO
4.	Do you have trouble breathing through your nose?	YES	NO
	a. One side or both *(circle)*		
	b. Year round or seasonal *(circle)*		
5.	Have you broken your nose?	YES	NO
6.	Have you had nasal surgery?	YES	NO
7.	Type of surgery?		
	a. Where and when? _____		
8.	Have you had prior tonsil, adenoid or palate surgery? (circle)	YES	NO
9.	Do your teeth fit together properly?	YES	NO
10.	Do you have trouble opening your mouth?	YES	NO
11.	Do you gag easily?	YES	NO
12.	Do you smoke cigarettes?	YES	NO
13.	How much alcohol do you drink per day on average? _____ drinks per day		
14.	Do you drink alcohol near bedtime?	YES	NO
15.	Do you have high blood pressure?	YES	NO
16.	Do you have an irregular heartbeat?	YES	NO
17.	Do you need SBE prophylaxis for your heart?	YES	NO
18.	Do you have a neurological disease?	YES	NO
19.	Do you have diabetes or thyroid disease? *(circle)*	YES	NO
20.	Are you a professional voice user?	YES	NO
21.	Do you play a wind instrument?	YES	NO
22.	Does anyone else in your family snore or have a sleep problem?	YES	NO
23.	Are you on anticoagulant therapy? *(medications to prevent blood clotting)*	YES	NO