INFORMATIONAL QUESTIONNAIRE
SNORING AND SLEEP APNEA

NAME _____ DATE _____

AGE _____ MALE___ FEMALE ___ WEIGHT _____ HEIGHT _____

1. What time do you go to bed? _____ What time do you start your day? _____
2. Do you have difficulty falling asleep in the beginning of the night? YES NO
   If yes, on average, how long does it take to fall asleep? _____
3. Do you have difficulty staying asleep throughout the night? YES NO
   How long does it take to fall back to sleep? _____
4. Do you experience an unsettled, restless sensation in your legs while sleeping? YES NO
   If yes, how frequently? _____Occasionally _____50% _____Every night
5. Have you been told that you make kicking and twitching movements while sleeping? YES NO
6. Do you snore at night? YES NO
   If yes, how would you rate the severity? ____ Mild ____ Moderate ____ Severe
7. Have you been told that you have pauses in your breathing while asleep? YES NO
8. Does your bed partner frequently sleep in another room because of how you sleep? YES NO
9. Do you frequently wake up with (check all that apply)
   ___ Dry mouth ___ Headaches ___ Excessive sweating ___ Choking or gasping
   ___ Nasal congestion ___ Chest pain ___ Heart burn ___ Drooling on pillow?
10. Are you sleepy during the day? YES NO
11. Do you take naps often? YES NO If yes, for how long? _____
12. How many caffeinated beverages do you consume each day? _____
13. Do you occasionally awaken feeling paralyzed? YES NO
14. Do you experience sudden loss of strength in your legs or arms during the day? YES NO
    If yes, are these brought on by a sudden frightening event or laughter? YES NO
15. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

0 = Never Doze 1 = Slight Chance 2 = Moderate Chance 3 = High Chance

Situation	**Chance of Dozing**			
Sitting and reading	0	1	2	3
Watching T.V.	0	1	2	3
Sitting, inactive in a public place (theatre)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Please list your medications:

_____

_____

Please list any medical conditions, past and present:

_____

_____