Eastern Oklahoma
Ear, Nose & Throat, Inc.

SNORING/SLEEP APNEA QUESTIONNAIRE

Date: ____________________

Patient's Last Name: ____________________ First Name: ____________________ Middle Initial: ________

SSN#: ____________________

Street Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Home Phone: ____________________ Business Phone: ____________________

Alternate Contact Name: ____________________ Phone: ____________________ Relationship: ____________________

Age: ____________________ Sex: ☐ Male ☐ Female

Please answer each of the following questions as completely as you can. These questions will help us evaluate the degree of your snoring problem and the success of your treatment.

1. How bad do you rate your snoring? ☐ Not a problem ☐ Not bad ☐ Bad ☐ Very bad ☐ Extremely bad
2. How bad do other people rate your snoring? ☐ Not a problem ☐ Not bad ☐ Bad ☐ Very bad ☐ Extremely bad
3. Is your snoring getting worse? ☐ Yes ☐ No
4. Does your spouse sleep in the same room that you do? ☐ Yes ☐ No
5. Does your spouse wear earplugs to bed? ☐ Yes ☐ No
6. Do you fall asleep easily? ☐ Yes ☐ No
7. Do you fall asleep while driving? ☐ Yes ☐ No
8. Can people hear you snore in the next room? ☐ Yes ☐ No
9. Do you ever wake up choking? ☐ Yes ☐ No
10. Do you wake yourself up because of your own snoring? ☐ Yes ☐ No
11. Do you fall asleep at work? ☐ Yes ☐ No
12. Have you ever been diagnosed with sleep apnea? ☐ Yes ☐ No
    When? ____________________
    By whom? ____________________
13. Have you ever been treated for sleep apnea? ☐ Yes ☐ No
    When? ____________________
    By whom? ____________________
    Where? ____________________
    How were you treated? ____________________
    ____
14. Have you ever been treated for snoring? ☐ Yes ☐ No
    When? ____________________

By whom? ______________________________

Where? ______________________________

How were you treated? ______________________________

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15. If you have ever been treated for snoring, has the snoring recurred? ☐ Yes ☐ No

16. Has anyone told you that you stop breathing while you are asleep? ☐ Yes ☐ No

17. Are you tired in the morning when you wake up? ☐ Yes ☐ No

18. Do you have morning headaches when you wake up? ☐ Yes ☐ No

19. Can you breathe through your nose? ☐ Yes ☐ No

20. Do you have allergies or hay fever? ☐ Yes ☐ No

21. Have you ever had a broken nose or nasal surgery? ☐ Yes ☐ No

22. Are you sleepy during the day? ☐ Yes ☐ No

23. Past medical history. Do you or have you had any of the following?

Condition	Yes	No
High blood pressure	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Irregular heart beat	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Lung disease	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Bleeding tendencies	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

Please explain: ______________________________

____

____

24. Have you had any previous surgeries? Please list with approximate dates:

____

____

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25. Do you have any drug allergies? ☐ Yes ☐ No

if yes, please list: ______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

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