MINNEAPOLIS OTOLARYNGOLOGY
SNORING AND SLEEP APNEA QUESTIONNAIRE

NAME______________________________ DATE_________________

AGE_________ SEX_________ WEIGHT_____________ HEIGHT_____________

Alcohol Consumption ☐ None ☐ 1-3 Times Weekly ☐ Daily

Evaluation of snoring as reported by bed-partner (circle one):

0 1 2 3 4 5 6 7 8 9 10

0 – 3: Occasional soft snoring – not bothersome to bed partner
4 – 6: Persistent snoring – bothersome to bed partner
7 – 9: Persistent loud snoring – frequently annoying bed partner
10: Heroic snoring – continuous, loud snoring not tolerated by bed-partner

1. How long have you been a snorer?________________________________

2.	Has your snoring awakened you?		Yes	No
3.	Has your companion ever moved to another room?		Yes	No
4.	Do you snore while sleeping on your:	Back	Yes	No
		Stomach	Yes	No
		Side	Yes	No
5.	Difficulty waking up in the morning?		Yes	No
6.	Difficulty staying awake during the day?		Yes	No
7.	Difficulty staying awake while driving?		Yes	No
8.	Difficulty breathing through your nose?		Yes	No
9.	Mouth breathing at night (dry mouth in the morning)?		Yes	No
10.	Excessive movements during sleep?		Yes	No
11.	Wake up during the night gasping for air?		Yes	No
12.	Have you had a recent significant weight gain?		Yes	No

If yes, please note gain of _____ pounds over the past _____ months.

13.	Weight management program within the year? Type___________		Yes	No
14.	Any observed periods at night when you stop breathing?		Yes	No

15. Have you had a sleep study? ☐ Yes ☐ No

When______________________ Where__________________________