



Sleep Apnea Questionnaire

Patient Name: _____

Date of Birth: _____

- 1) Do you have a family member or sleep partner who has watched your sleep problem? Y / N
 - a. (If so, please ask them to help you complete portions of this questionnaire regarding your hours of sleep. If not, please answer based on your best knowledge.)

- 2) Do you snore? Y / N
 - a. If so, how often? rarely, occasionally, frequently, constantly when asleep
 - b. How severely from 1-10? 1 = light doesn't bother sleep partner at all. 10 = extremely loud and so disruptive that a sleep partner could not possibly expect to sleep with that snoring going on. _____
 - c. Do you stop breathing for periods of time followed by a gasp or deep breath? Y / N

- 3) Are you sleepy during the day even after a good night's sleep? Y / N

- 4) Do any of your blood relatives have sleep apnea? Y / N

- 5) Do you have a history of heart surgery, heart attack, stroke, high blood pressure? Please specify: _____

- 6) Have you ever had a sleep study? Y / N If yes, where? _____

- 7) Have you ever used CPAP or Bi PAP for sleep apnea? If yes, please tell us who prescribed it.

- 8) If you had difficulty with the CPAP device, please explain why you had trouble with it:

- 9) Do you have nasal congestion, sinus problems, chronic stuffy nose? Y / N If yes, please complete Nasal/ Sinus Questionnaire.

- 10) Have you had your tonsils removed? Y / N

- 11) Have you had any other surgery on your nose or throat? Please describe:
