



Adult and Pediatric Otolaryngology
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Sleep Questionnaire

Name: _____ Date: _____

DOB: _____ Sex: _____ Height: _____ Weight: _____ Neck Size: _____

Chief Complaint: (Check one)

Snoring Sleepiness/Fatigue Other: _____

Snoring

- | | | | |
|---|-----|----|-------------|
| 1. Do you snore no matter what position you are lying in? (Circle One) | Yes | No | Do Not Know |
| 2. Do you snore every night? (Circle One) | Yes | No | Do Not Know |
| 3. Is your snoring interrupted by pauses and/or choking sounds? (Circle One) | Yes | No | Do Not Know |
| 4. Has your sleep mate ever commented on your snoring? (Circle One) | Yes | No | N/A |
| 5. Do you “grind” your teeth at night? (Circle One) | Yes | No | Do Not Know |
| 6. Do you have high blood pressure? (Circle One) | Yes | No | Do Not Know |
| 7. On a scale from 1-10, with 10 being the loudest, how loud is your snoring? _____ | | | |
| 8. Other comments: _____ | | | |

Sleepiness/Fatigue

1. How would you describe yourself? (Check all that apply)

Fatigued Sleepy Tired Other: _____

2. What tasks or activities have you eliminated or find difficulty in completing?

3. What is your energy level on a scale of 1-10? (Circle one)

No energy ← 1 2 3 4 5 6 7 8 9 10 → Very high energy

4. Other comments: _____



Sleep

1. Around what time to you usually fall asleep? _____
2. Around what time to you usually wake up? _____
3. Is it difficult to fall back asleep if you wake up during the night? (Check one) Yes No
4. How often do you wake up during the night (bathroom, clock, noises, etc...)?
 Never Rarely Sometimes Frequently
5. What is the quality of your sleep on a scale from 1 to 10? (Circle one)
 Very Poor ← 1 2 3 4 5 6 7 8 9 10 → Excellent
6. Other comments: _____

Other Symptoms (check all that apply)

- | | | | |
|-------------------------------------|---|---|-----------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Impotence | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Headache |

History

1. Have you ever been treated for your snoring or sleep disorder? (Circle one)
 Yes No Do Not Know
2. If Yes, please fill out the following:
 Provider Name: _____ Provider Phone Number: _____
 Provider Address: _____
 Date of the evaluation: _____
 Diagnosis: _____
 Describe any treatment that you may have received and the success and/or failure you experienced. _____

