

1. Complete the following:
Height _____ Age _____
Weight _____ Male/Female _____
Has your weight changed? _____

2. Do you snore?
 Yes
 No
 Don't know

If you snore:

3. Your snoring is . . .
 Slightly louder than breathing
 As loud as talking
 Louder than talking
 Very loud

4. How often do you snore?
 Almost every day
 3-4 times a week
 1-2 times a week
 Never or almost never

5. Does your snoring bother other people?
 Yes
 No

6. Has anyone noticed that you quit breathing during your sleep?
 Almost every day
 3-4 times a week
 1-2 times a week
 Never or almost never

7. Are you tired after sleeping?
 Almost every day
 3-4 times a week
 1-2 times a month
 Never or almost never

8. Are you tired during waketime?
 Almost every day
 3-4 times a week
 1-2 times a month
 Never or almost never

9. Have you ever nodded off or fallen asleep while driving?
 Yes
 No

If yes, how often does it occur?

Every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 Never or almost never

10. Do you have high blood pressure?
 Yes
 No
 Do not know

Name: _____

Address: _____

City: _____ State: _____ Zip: _____