SLEEP & SNORING EVALUATION QUESTIONAIRE Date: _____

Sex: _____ Female _____ Male

Marital Status: ____ Single ____ Married ____ Domestic Partner

____ Divorced ____ Divorced ____ Divorced-Remarried

____ Separated ____ Widowed

Race: ____ Caucasian ____ Asian ____ African American

____ Hispanic ____ Other (specify): _____

Is there usually a bed partner to observe you sleep? ____ Yes ____ NO

During the last week:

	NEVER	RARELY	SOMETIMES	OFTEN
Have you snored or have you been told that you do?				
Have you had a choking or shortness of breath sensations at night?				
Have you woken up during sleep?				
Have you had morning fatigue, fogginess or woken up feeling unrefreshed?				
Have you woken up with a headache?				
Have you had chronic sleepiness, fatigue or weariness that you can't explain?				
Have you fallen asleep reading or watching television?				
Have you fallen asleep during the day, particularly when not busy?				
Have you fallen asleep during the day against your will?				
Have you had to pull off the road while driving due to sleepiness?				
Have you been more irritable and short-tempered?				
Have you been told that you stop breathing while sleeping?				
Have you felt your memory and/or intellect is impaired?				