



Bay Area Sleep Center

3100 Shore Drive, Marinette, WI 54143

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Sleep Questionnaire

Name: _____

Date: _____

Please answer the following questions about your sleep:

1. Do you snore?
 No **(If no, proceed to Question 6)**
 Yes (If yes, answer all questions)

2. My snoring is:
 Slightly louder than breathing
 As loud as talking
 Louder than talking
 Very loud

3. How often do you snore?
 Don't know
 Once or twice a month
 Once or twice a week
 Three to four times a week
 Almost every day

4. Does your snoring bother other people?
 No
 Yes

5. Do you stop breathing during sleep?
 No
 Once or twice a month
 Once or twice a week
 Three to four times a week
 Almost every day

6. Do you feel tired after you sleep?
 No
 Once or twice a month
 Once or twice a week
 Three to four times a week
 Almost every day

7. While you are awake, do you feel tired?
 No
 Once or twice a month
 Once or twice a week
 Three to four times a week
 Almost every day

8. Do you fall asleep while driving a vehicle?
 No
 Once or twice a month
 Once or twice a week
 Three to four times a week
 Almost every day

9. Do you have a history of high blood pressure?
 No
 Yes

For Clinical Personnel		
BMI: _____	Section 1 <input type="checkbox"/>	Risk for Sleep Apnea
BP: _____	Section 2 <input type="checkbox"/>	<input type="checkbox"/> Low
	Section 3 <input type="checkbox"/>	<input type="checkbox"/> High