Pulmonary Internists
2 Lincoln Highway, Suite 301, Edison, NJ 08820
3 Hospital Plaza, Suite 205, Old Bridge, NJ 08857

Patient Name: _____

Please complete the following questionnaire.

1. Snoring

a) Do you snore on most nights (>3 nights per week)?
Yes (2) No (0) _____

b) Is your snoring loud enough to be heard through a door or wall?
Yes (3) No (0) _____

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0) Occasionally (3) Frequently (5) _____

3. What is your collar size?

Male: Less than 17 inches (0) more than 17 inches (5) _____

Female: Less than 16 inches (0) more than 16 inches (5) _____

4. Have you had or are you being treated for high blood pressure?

Yes (5) No (0) _____

TOTAL _____

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0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of dozing**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes	_____
TOTAL	_____