JULIAN CENTER
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SNORING EVALUATION

Date: _____

Name:	Age: _____	Sex: M F
Birth Date:	Height:	Weight: lbs.

Please answer the following questions by indicating the frequency according to these guidelines.

Always	Every or almost every night or day
Often	At least once a week, but less than "always"
Rarely	Less than once a week
Never	Never during a usual night or day

During your usual sleep, have you noticed or have you been told that you do the following? (Check one answer in each category)

	Always	**Often**	**Rarely**	**Never**
Snore loudly				
Choke, struggle for breath or stop breathing				
Awaken repeatedly because of a breathing problem				
Toss and turn frequently				
Kick or jerk leg(s)				

When you wake up after your usual sleep, how often do you experience the following:

Headache				
Dry Mouth				
Feel tired or not well rested				

During your normal awake time, (daytime and/or evening) how often do you become extremely sleepy or fa
asleep in the following situations

	Always	Often	Rarely	Never
After a meal				
Reading or watching television				
At church or school				
At work				
While a passenger in a car or truck				
While driving a car or truck				

Do you have trouble breathing through your nose? (Check one answer in each category)

	Always	Often	Rarely	Never
Daytime				
Night time, in bed				

Please check Yes or No to the following:

	Yes	No
Have you ever had a broken nose?		
Have you ever had nose surgery?		
Have you had a tonsillectomy?		
Do you take any medications?		
Do you suffer from hay fever?		
Do you have sinus problems?