SNORING SYMPTOMS INVENTORY

Name. ……Date…….. ….

Hospital Number …… Date of Birth…….

PLEASE ANSWER THE FOLLOWING STATEMENTS WITH YOUR FIRST IMPRESSION (please tick)

		Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
1	My sleep is disturbed					
2	My family complains about my snoring					
3	I feel tired					
4	I am concerned about disturbing my partner's sleep or the sleep of others in the home					
5	I have a dry mouth or throat					
6	I am embarrassed when I stay overnight with friends or relatives					
7	I have a blocked nose					
8	Because of my snoring, I sometimes have to sleep in a separate room to my partner or others in the home					
9	I am concerned that my snoring puts a strain on my personal relationship(s)					
10	I worry about falling asleep whilst driving					
11	I am embarrassed when I am on holiday or staying in hotels					
12	I feel bad tempered and irritable					
13	I sometimes fall asleep during the day					
14	I have a sore throat					
15	My sex life has been affected my snoring					
16	I have problems concentrating on my work					
17	My neighbours complain about my snoring					
18	I am unable to concentrate during the day					
19	I lack self confidence					
20	I have a choking feeling					
21	I feel depressed because I cannot do anything about my snoring					
22	I get headaches					
23	I have problems breathing					
24	I feel frightened of going to sleep					
25	I am embarrassed by my snoring					
		Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

Score: Strongly agree =4, Agree =3, Neither= 2, Disagree = 1, Strongly disagree = 0

TOTAL = ……

The Development of a Snoring Symptoms Inventory (SSI). S A Douglas, S Webster, M Reda, M Drinnan, JNS Matthews, G J Gibson, J A Wilson *Otolaryngol Head Neck Surg*. 2006 Jan;134(1):56-62