Date:_____

SNORING AND SLEEP APNEA SCREEN QUESTIONNAIRE

Patient's Name:_____
Last First Middle

Occupation:_____ Working Hours: From____ To_____

Referred by: _____ Address_____

Height:_____ Weight_____ (% of ideal weight) Neck size_____
Year gained_____ Amount gained_____

_____

SNORING:

How many years have you been told you snore?_____

Does your snoring disturb your bed partner? Yes____ No____
Others in the next room? Yes____ No ____

Has your snoring become progressively worse: Yes____ No____
Over what period of time?_____

Do you snore every night? Yes____ No____

Have you been told you snore when sleeping:
On your back (+,-) On your side (+,-)
On your stomach (+,-) In a sitting position (+,-)

Have you ever been awakened from sleep by your snoring? Yes____ No____

Does any other family member snore? Yes____ No____
If yes, relation:_____

Snoring and Sleep Apnea Screen Questionnaire

EXCESSIVE DAYTIME SLEEPINESS:

1. Do you regularly experience daytime sleepiness? Yes___ No___
   A lot_____ Moderate _____ A little____

   What time of the day? _____ How many times per day?_____

   When did daytime sleepiness start?_____

2. If inactive or relaxed, do you usually fall asleep? Yes____ No____
   On the job? (+, -), at home? (+, -), at any place? (+,-) at any time? (+,-)

3. When motivated, are you able to remain awake? Yes___ No____

4. Do you usually feel tired during the day? Yes____ No____

5. Do you frequently take a nap during the day? Yes____ No_____
   How many naps per day? _____ Length_____ do you feel refreshed
   after a nap? Yes_____ No_____

6. Do you experience drowsiness or a tendency to call asleep
   driving? Yes____ No____ Short distances? (0-1 hr.) (+,-)
   Approximate time_____ Long distance? (More than one hour) (+,-)
   Approximate time_____

7. Have you been in a car accident due to falling asleep at
   the wheel? Yes____ No____ Near miss____

8. Have you every suddenly fallen or experienced sudden bodily weakness?
   (cataplexy) Yes____ No_____

9. Have you recently noticed increased irritability, moodiness,
   or trouble thinking? Yes____ No____

Snoring and Sleep Apnea Questionnaire

SLEEP STATUS:

1. On the average, how long does it take you to fall asleep at night after you turn out your bedroom light?
   _____ minutes.

2. Do you have difficulty falling and/or staying asleep?
   Yes____ No_____

3. Write in the times you usually go to bed and get up:
   On weekdays: go to bed _____ a.m./p.m. get up_____a.m./p.m.

   On weekends: go to bed_____ a.m./p.m. get up_____a.m./p.m.

4. On the average, how long are you actually asleep at night? _____ hours.

5. Do you awaken frequently from sleep during the night? Yes_____ No_____

6. Have you ever awakened with choking or gasping for breath? Yes____ No____

7. Upon awakening, do you feel refreshed and rested? Yes____ No____

8. How difficult is it for you to awaken and get out of bed after sleeping?
   very difficult?____ difficult____ sometimes difficult____ no problem____

9. Do you or your bed partner ever notice any frequent arm or leg movements during sleep? Yes____ No____

Snoring and Sleep Apnea Questionnaire

MEDICAL HISTORY:

1. Do you have difficulty breathing through your nose? Yes____ No____
   If yes, all day (+,-) only at night (+,-)

2. Have you had:

   a) Tonsillectomy and/or adenoidectomy? Yes____ No____
      If yes, when?_____
   b) Nasal or sinus surgery? Yes____ No____ If yes, when?_____
   c) Vocal cord surgery (polyp, nodules, etc.) Yes____ No_____
      If yes, when?_____
   d) Other Head & Neck operations? Yes____ No____
      If yes, when?_____

3. Do you have:

   1. Hypertension Yes____ No_____
   2. Heart disease Yes____ No_____
   3. Morning headaches Yes____ No_____
   4. Sexual problem Yes____ No_____
   5. Pulmonary disease (emphysema or asthma) Yes____ No____
   6. Thyroid disease Yes____ No_____
   7. Allergy Yes____ No_____

4. GENERAL HEALTH:_____
   _____

5. MEDICATIONS:_____
   _____
   _____

   Do you smoke? Yes____ No____ If yes, how many cigarettes/packs a day?_____

   Do you drink alcoholic beverages? Yes____ No____ If yes, how much per day?_____

Snoring and Sleep Apnea Questionnaire

ANY FURTHER COMMENTS REGARDING YOUR CONDITION NOT COVERED IN THIS FORM?

_____
_____
_____
_____
_____

PLEASE RETURN TO:

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