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 ever 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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