

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 fall 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? \_\_\_\_\_

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Snoring and Sleep Apnea Questionnaire

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

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PLEASE RETURN TO:

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