

The Ear, Nose and Throat Surgical Associates, P.A.

**QUESTIONNAIRE FOR PATIENTS WITH
SNORING AND POSSIBLE SLEEP APNEA
(Patients 17 years or older)**

Date Form Filled Out: _____

PERSONAL DATA

Name: _____
(Last) (First) (M.I.)

Work Phone: _____ Date of Birth: _____

Sex: Male Female Weight: _____ Height: _____ Neck Size: _____

BMI: _____ (To Be Completed by Physician)

Are You a: Singer Actor Announcer Clergy Other: _____

BACKGROUND INFORMATION

1. In your own words, please describe the nature and severity of your problem and why you came here.

2. How long have you had this problem? _____
3. Would you describe your snoring problem as: Mild Moderate Severe
4. Would you describe other people's perception of your snoring problems as: Mild Moderate Severe
5. Has your snoring or sleep problem affected your job performance? Yes No
6. Has your snoring or sleep problem affected your personal life? Yes No
7. Have you ever been evicted from your bedroom or has your companion left the room because of your snoring? Yes No
8. Do you snore in every position? Yes No
9. Have you had any treatment for snoring? Yes No
If yes, please describe: _____
10. Do you play a wind instrument? Yes No
11. Have you had any auto accidents related to falling asleep? Yes No
12. Has anyone who sleeps with you mentioned that you stop breathing or gasp for breath when sleeping? Yes No
13. Have you had your tonsils removed? Yes No
14. Have you gained any weight recently? How much? _____ Yes No
15. Do you have any thyroid disorders? Yes No
16. Have you had any prior nasal surgery? Yes No

(Continued on Back)

Patient Name: _____ Date: _____

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17. Have you ever had a sleep study? Yes No
If yes, where: _____ When: _____
Results: _____
18. Have you ever been on CPAP? Yes No
19. Do you wake up in the morning with dull headaches? Yes No
20. Do you use any form of tranquilizers or sleeping pills? Yes No
21. Do you have a job which requires you to be up all night or to keep odd hours? Yes No
If yes, please describe: _____
22. Have you had a history of nasal allergy? Yes No
23. Have you had any significant problems with nasal obstruction? Yes No

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0=would *never* doze 1=*slight* chance of dozing
2=*moderate* chance of dozing 3=*high* chance of dozing

SITUATION

CHANCE OF DOZING

- | | |
|--|-------|
| 1. Sitting and reading | _____ |
| 2. Watching television | _____ |
| 3. Sitting, inactive in a public place (e.g. a theater or a meeting) | _____ |
| 4. As a passenger in a car for an hour without a break | _____ |
| 5. Lying down to rest in the afternoon when circumstances permit | _____ |
| 6. Sitting and talking to someone | _____ |
| 7. Sitting quietly after lunch without alcohol | _____ |
| 8. In a car, while stopped for a few minutes in the traffic | _____ |