The Ear, Nose, Throat and Plastic Surgery Associates

New Sleep Patient History Questionnaire

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<tr>
<th>Patient Name: ________________________________</th>
<th>Date of Birth: ____________________</th>
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**Sleep Habits**

Describe your Average Night Sleep

<table>
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<tr>
<th>Bedtime</th>
<th>Time Get Up</th>
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<tr>
<td>_______________ AM/PM</td>
<td>_______________ AM/PM</td>
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How Long to Fall Asleep

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Estimated Hours of Sleep each night

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How many times do you wake up in the middle of the night?

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Length of Each Awakening

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Do you take naps during the day? Yes/No

If yes, how many? ______ For how long do you nap? ______

**Sleep Breathing & Snoring**

Snoring: Yes _____ No _____ Don't Know _____ If yes, has it recently worsened ______

Snoring Positions: Back Only ____ All Positions ____

Do others observe you choke or stop breathing? Yes No

Have you been diagnosed with Sleep Apnea in the past? Yes No

Do you use, or have you ever used a CPAP device? Yes No

Is your nose congested at night? Yes No

Do you breathe only through your mouth at night? Yes No

Do you feel refreshed when you wake up in the morning? Yes No

Do you have heartburn or acid reflux? Yes No

**Other Sleep History**

Do you have trouble falling asleep? Yes No

Do you have trouble staying asleep? Yes No

Have thoughts racing through your mind, anxiety or worry? Yes No

Do you feel afraid of not being able to sleep? Yes No

Do you have body pain or discomfort at night? Yes No

Do you have a diagnosis of anxiety or depression? Yes No

Do you use an alarm to waken? Yes No

Do you wake up feeling tired/fatigued in the morning? Yes No

Do you feel sleepy during the day when you are sitting or not active? Yes No

Do you feel drowsy or sleepy when driving? Yes No

Have you ever been in an accident from sleepy driving? Yes No

Do you feel muscle weakness when laughing, surprised, or angry? Yes No

Do you ever feel unable to move/paralyzed when waking up? Yes No

Have vivid images or sounds (dream-like) when falling asleep or waking even though you are awake? Yes No

Do you have creeping or crawling leg discomfort in the evening/night? Yes No

If yes, does this get better when you move your legs? Yes No

Do you ever sleepwalk, sleeptalk or wake up confused? Yes No

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9/30/14
Patient Name: ________________________________ Date of Birth: ____________________

**EPWORTH Sleepiness Scale**
Please rate how likely you are to fall asleep in each of the following situations:

Ratings: 0 = Never Doze  
1 = Slight Chance of Dozing  
2 = Moderate Chance of Dozing  
3 = High Chance of Dozing

1. Sitting and reading  
2. Watching television  
3. Sitting inactive in a public place (meetings, theater, etc.)  
4. A passenger in a car for one hour without a break  
5. Lying down 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 traffic  

Total___________

**NOSE Scale**
Over the past ONE MONTH, how much of a problem were the following conditions for you?

Ratings: 0 = No Problem  
1 = Mild Problem  
2 = Moderate Problem  
3 = Fairly Bad Problem  
4 = Severe Problem

1. Nasal congestion or stuffiness 0 1 2 3 4  
2. Nasal blockage or obstruction 0 1 2 3 4  
3. Trouble breathing through my nose 0 1 2 3 4  
4. Trouble sleeping 0 1 2 3 4  
5. Unable to get enough air through my nose during exercise or exertion 0 1 2 3 4  
6. Snoring 0 1 2 3 4  

**SNORING Scale**
(Circle appropriate number)

Rate your **snoring loudness**.  
Very Quiet ---------------------------------------------Very Loud  
1 2 3 4 5 6 7 8 9 10  

Is your snoring (circle one):  
+Continuous, every night  
+ Intermittent, every night  
+ Not every night

How **important** is your snoring?  
Not Important --------------------------------------------Very Important  
1 2 3 4 5 6 7 8 9 10

How **bothersome** is your snoring to others?  
Not Severe ---------------------------------------------Very Severe  
1 2 3 4 5 6 7 8 9 10

9/30/14