



Snoring Questionnaire

Name _____ Date _____

Age _____ Date of Birth _____ Sex Male / Female Neck size _____

Height _____ Weight _____ Marital Status Single/Married/Separated/Divorced/Widowed

Medical History

Hypertension	Yes/No	Thyroid Disease	Yes/No
Irregular Heart Beat	Yes/No	Asthma	Yes/No
Sleep Apnea	Yes/No	Sinusitis	Yes/No
Heart Failure	Yes/No	Diabetes	Yes/No

Past Surgical History (Include dates of surgery)

Tonsillectomy	_____	Adenoidectomy	_____
Nasal Septal Surgery	_____	Sinus Surgery	_____
Uvulopalatoplasty (UPPP)	_____	LAUP	_____
Tracheostomy	_____	Maxillofacial	_____

Current Medications and Dosage

Do you have any allergies to medications? _____ If so, please list them. _____

Do you smoke? Yes/No Cigarettes per day _____

Do you drink alcohol? Yes/No How much? _____

Gained weight recently? Yes/No How much? _____

Lost weight recently? Yes/No How much? _____

Do you exercise? Never / Rarely / Occasionally / Frequently / Daily

Have you ever been diagnosed with sleep apnea? Yes/No If yes, when? _____

What physician diagnosed you with this? _____

Have you ever had a polysomnogram (sleep study)? Yes/No

If yes, it is important to bring a copy of this test to your appointment.

Have you ever used a CPAP or a BiPAP machine? _____ If so, for how long? _____

(OVER)

Have you ever been evicted from your bed or bedroom?	Yes/No
Has your companion ever moved to another room?	Yes/No
Are you able to share a hotel room with a travel companion?	Yes/No
Do you snore while sleeping on your.....Back	Yes/No
.....Stomach	Yes/No
.....Side	Yes/No
Difficulty waking up in the morning?	Yes/No
Difficulty staying awake during the day?	Yes/No
Difficulty staying awake while driving?	Yes/No
Difficulty with your memory?	Yes/No
Difficulty breathing through your nose?	Yes/No
Mouth breathing at night (Dry mouth in the morning)?	Yes/No
Excessive movements during sleep?	Yes/No
Wake up during the night gasping for air?	Yes/No
Awaken during the night with your heart pounding?	Yes/No
Narcolepsy (Falling asleep involuntarily during the day)?	Yes/No
Has anyone observed periods at night when you stop breathing?	Yes/No

Evaluation of snoring as reported by bed partner (circle one):

0 1 2 3 4 5 6 7 8 9 10

- 0-3 Occasional soft snoring - not bothersome to bed partner
- 4-6 Persistent snoring - bothersome to bed partner
- 7-9 Persistent loud snoring - frequently annoying bed partner
- 10 Heroic snoring - continuous, loud snoring not tolerated by bed partner

Comments or other information not included above: _____

THE EPWORTH SLEEPINESS SCALE

Name: _____

Today's date _____ Your age _____

Your sex (male=M, female=F) _____

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
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (Example: a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Thank you for your cooperation.

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