Snoring and Sleep Disorders

Name:______________________________

Date:__________________________

Birth Date:____________________ Age:________ Sex: M_____F_____

1. How many years have you snored--total? ________
2. How many years has snoring been a problem (if different from question 1)? __________
3. Number of nights per week your spouse sleeps in another room because of snoring? (If none, put 0)________
4. How many hours do you sleep per night?________
5. What was your weight: when you finished high school?__________
   1 year before you began snoring?_________
   1 year before snoring became a problem?_________

Check YES, NO, or DON'T KNOW and fill blank spaces. If possible, give the response of your spouse or roommate. Leave blank if neither of you know.

YES	NO	DON'T KNOW	
			6. Snore in which positions:
[ ]	[ ]	[ ]	All positions?
[ ]	[ ]	[ ]	Back?
[ ]	[ ]	[ ]	Other?
			7. Do you snore:
[ ]	[ ]	[ ]	Every night? If NO, how many nights per week?________
[ ]	[ ]	[ ]	All night? If NO, how many hours per night?_________
[ ]	[ ]	[ ]	Immediately on falling asleep?
[ ]	[ ]	[ ]	After sleeping a few hours?
[ ]	[ ]	[ ]	After several hours?
			8. Do you:
[ ]	[ ]	[ ]	Stop breathing?
[ ]	[ ]	[ ]	Gasp for air?
[ ]	[ ]	[ ]	Stop breathing without gasping?
[ ]	[ ]	[ ]	Awaken yourself? If YES, how many times per night? _______
[ ]	[ ]	[ ]	Awakened by spouse or roommate? If YES, how many times per night______
			9. In the morning:
[ ]	[ ]	[ ]	Are you refreshed? How refreshed? (1 no sleep to 10 best ever)________
[ ]	[ ]	[ ]	Have a headache?
			10. Do you fall asleep:
[ ]	[ ]	[ ]	In a dark or quiet room?
[ ]	[ ]	[ ]	In conferences?
[ ]	[ ]	[ ]	While driving?
[ ]	[ ]	[ ]	Mid conversation?

			11. Snoring disturbs:
[ ]	[ ]	[ ]	Spouse/roommate?
[ ]	[ ]	[ ]	People in other rooms?
[ ]	[ ]	[ ]	People on different floor?
[ ]	[ ]	[ ]	12. Do you use sleeping pills? If YES, how many times per week? ____

Do you have any of the following NASAL problems? Check the box if YES, leave blank is NO or unknown.

[ ] blocked nose [ ] frequent congestion [ ] mouth breath with exercise [ ] mouth breath at night

[ ] clear drainage [ ] sinus infections [ ] pus (green/yellow) drainage [ ] blocked ears

[ ] polyps [ ] sinus surgery [ ] use decongestant nose spray; how often?________

[ ] nasal or sinus surgery (list) ____

[ ] seasonal allergies (list) ________________________ [ ] year round allergies (list) ________________________

OTHER: [ ] memory lapses [ ] heartburn [ ] bronchitis [ ] ulcer [ ] high blood pressure

---

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

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

Sitting and Reading	________
Watching TV	________
Sitting inactive in a public place (meeting, theater, etc.)	________
As a passenger in a car for 1 hour without a break	________
Lying down in the afternoon when circumstances permit	________
Sitting and talking to someone	________
Sitting quietly after lunch without alcohol	________
In a car, while stopped for a few minutes in traffic	________
TOTAL:	____________