SNORING PATIENT QUESTIONNAIRE

Name: Last_________________________________   First_________________________  MI ______

Height:__________ ft_______  in  Weight: ____________ lbs Shirt collar size:___________

Language(s) routinely spoken: (list in order of most used to least used) ______________________________________

Who referred you to this office?(circle)  Self  Spouse  Mate  Parent(s)  Child(ren)  Friend(s)  Advertisement

Physician (specify) ___________________ Other______________

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

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing</th>
<th>Situation</th>
<th>Chance of Dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>______</td>
<td>Lying down in the afternoon</td>
<td>______</td>
</tr>
<tr>
<td>Watching TV</td>
<td>______</td>
<td>Sitting and talking to someone</td>
<td>______</td>
</tr>
<tr>
<td>Sitting, inactive in public</td>
<td>______</td>
<td>Sitting quietly after lunch (no alcohol)</td>
<td>______</td>
</tr>
<tr>
<td>Car passenger (for an hour)</td>
<td>______</td>
<td>Stopped for a few minutes in traffic</td>
<td>______</td>
</tr>
</tbody>
</table>

CIRCLE THE APPROPRIATE RESPONSE

How long have you had a snoring problem?  Less than 5 yrs / More than 5 yrs / More than 10 yrs
This problem (snoring) started: Suddenly / Gradually / Intermittently
Do you snore every night?    Yes  /  No
How many hours of sleep do you get at night?   _____________
Do you feel rested in the mornings?   Yes  /  No
How many pillows do you use?        _____________
Rate the effect of your problem on your PERSONAL LIFE  No effect / Mild / Moderate / Severe
Rate the effect of your problem on JOB PERFORMANCE  No effect / Mild / Moderate / Severe
What is the loudness of your snoring?    Mild / Moderate / Severe
How bothersome is this to your mate?    Mild / Moderate / Severe
Do you play a wind instrument?     Yes  /   No
If yes circle the category which best applies to you  Singer  /  Actor  /  Public Speaker
Clergy  /  Other (specify) ______________
Are you a vocal performer?      Yes  /   No
How motivated are you to alleviate the problem?   Mildly / Somewhat / Very
Have you ever been diagnosed with “SLEEP APNEA”?  If Yes – Where? (Clinic/Institution name)

Physician’s Name who treated you ______________________________________________________
Was a “Sleep Study” done?   Yes / No  If “Yes” – where? ______________________________________
Have you been TREATED for Sleep Apnea?    Yes / No
If “Yes” – describe the treatments ______________________________________________________
How effective was the treatment?   No Improvement / Mild Improvement/ Good Improvement

CIRCLE THE SYMPTOMS BELOW WHICH YOU FREQUENTLY HAVE

day time drowsiness          morning headaches          occasional bed wetting
fall asleep while driving    difficulty waking up     tire quickly
dizziness / loss of balance  fall asleep at work     poor memory
difficulty staying asleep     difficulty falling asleep        difficulty concentrating
numbness of tingling of fingers none of the above