

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

| <u>Situation</u> | <u>Chance of Dozing</u> | <u>Situation</u> | <u>Chance of Dozing</u> |
|-----------------------------|-------------------------|--|-------------------------|
| Sitting and reading | _____ | Lying down in the afternoon | _____ |
| Watching TV | _____ | Sitting and talking to someone | _____ |
| Sitting, inactive in public | _____ | Sitting quietly after lunch (no alcohol) | _____ |
| Car passenger (for an hour) | _____ | Stopped for a few minutes in traffic | _____ |

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

Are you a vocal performer? Yes / No

If yes circle the category which best applies to you Singer / Actor / Public Speaker

Clergy / Other (specify) _____

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 | |