Oregon Ear, Nose, and Throat Center
Snoring and Sleep Apnea Questionnaire

Name:_____ DOB:_____ Age:_____ Date:_____

Gender □ Male □ Female Neck size:_____ Weight 1 year ago:_____ Weight 5 years ago:_____

Curent weight:_____ Height:_____

Marital Status □ Single □ Married □ Seperated □ Divorced □ Widowed □ Domestic Partner

Previous Surgeries

			Year				Year
□No	□Yes	Tonsillectomy		□No	□Yes	Palate Implants or Injections	
□No	□Yes	Adenoidectomy		□No	□Yes	Nasal Septum Surgery	
□No	□Yes	Uvulopalatoplasty (UPPP)		□No	□Yes	Sinus Surgery	
□No	□Yes	Laser Assisted UPPP		□No	□Yes	Tongue Advancement	
□No	□Yes	Maxillo-Mandibular Advancement		□No	□Yes	Tracheotomy	

Medical History

□No	□Yes	Irregular rythym or pulse	□No	□Yes	Thyroid Problems
□No	□Yes	Congestive heart failure	□No	□Yes	Asthma
□No	□Yes	High blood pressure	□No	□Yes	Sinusitis
□No	□Yes	Sleep Apnea	□No	□Yes	Diabetes
□No	□Yes	Pacemaker	□No	□Yes	Other

□No □Yes Do you smoke? If yes: I smoke _____ packs of cigarettes a day for_____ years.

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

□No □Yes Gained weight recently? How much? _____

□No □Yes Lost weight recently? How much? _____

□No □Yes Do you excersize? □ Rarely □ Monthly □ Weekly □ Several times a week □ Daily

□No □Yes Diagnosed with sleep apnea? When?_____by which practitioner?_____

□No □Yes Have you ever had a polysomnogram (sleep study)?
If yes, it is important to bring a copy of this test to your appointment.

□No □Yes Have you ever used (please circle) CPAP or BIPAP How long? _____

□No □Yes Have you ever been evicted from your bed or bedroom?

□No □Yes Has your companion ever moved to another room?

□No □Yes Are you able to share a hotel room with a travel companion?

Do you snore while sleeping on your:

□No □Yes Back?

□No □Yes Stomach?

□No □Yes Side?

□No □Yes Difficulty waking up in the morning

□No □Yes Difficulty staying awake while driving

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□No	□Yes	Difficulty with your memory
□No	□Yes	Difficulty breathing through your nose
□No	□Yes	Mouth breathing at night (dry mouth in the morning)
□No	□Yes	Excessive movements during sleep
□No	□Yes	Wake up during the night gasping for air
□No	□Yes	Wake up with your heart pounding
□No	□Yes	**Any observed periods at night when you stop breathing?**

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

1 2 3 4 5 6 7 8 9 10

1-3	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

Rate your morning alertness or wakefullness

1 2 3 4 5 6 7 8 9 10

Very Alert, Rested — Very hard to get up, still very tired

Rate your job performance or alertness

1 2 3 4 5 6 7 8 9 10

Very alert, never nod off — Very hard to concentrate more than 5 minutes, frequently nod off if not active

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SLEEPINESS SURVEY

How likely are you to doze off or fall asleep in the following situations? This refers to your usual lifestyle recently. If you havent done a certain activity recently, imagine how likely you would be to fall asleep. Choose the **most appropriate number** from the following scale for each situation.

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

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching television	_____
Sitting, inactive in a public place (theatre or	_____
Passenger in a car for an hour without a break	_____
Lying down to rest in the afternooon when circumstances permit	_____
Sitting quietly after a lunch without alcohol	_____
Sitting and talking with someone	_____
In a car, while stopped for a few minutes in traffic	_____

COMMENTS OR OTHER INFORMATION NOT INCLUDED ABOVE

_____

_____

_____

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Information provided is accurate to the best of my knowledge.

X _____ X _____

Patient/Legal Representative Signature Date

I have reviewed this document with the patient or their legal representitive.

X _____ X _____

Physican Signature Date

_____

Physican Name (Printed)