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

Name_____ Date of Birth_____Age_____
Gender ☐ Male ☐ Female Neck size_____
Height_____Weight_____Weight one year ago_____Weight five years ago_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partner

Medical history			Medical history		
☐ No	☐ Yes	High blood pressure	☐ No	☐ Yes	Thyroid problems
☐ No	☐ Yes	Irregular rhythm or pulse	☐ No	☐ Yes	Asthma
☐ No	☐ Yes	Sleep Apnea	☐ No	☐ Yes	Sinusitis
☐ No	☐ Yes	Congestive heart failure	☐ No	☐ Yes	Diabetes
☐ No	☐ Yes	Pacemaker			

Previous surgeries			Year	Previous surgeries			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 Uvulopalatoplasty	_____	☐ No	☐ Yes	Tongue advancement	_____
☐ No	☐ Yes	Maxillo-mandibular advancement	_____	☐ No	☐ Yes	Tracheotomy	_____

Current Medications (list name, dosage, and frequency) Include vitamins and herbal supplements.

_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ No ☐ Yes Do you smoke? If yes, I smoke ____ packs of cigarettes/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 exercise? ☐ Rarely ☐ Monthly ☐ Weekly ☐ Several times a week ☐ Daily
☐ No ☐ Yes Diagnosed with sleep apnea? When_____ and by which practitioner? _____
☐ No ☐ Yes 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 (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?

Snoring and Sleep Apnea Questionnaire Page 2

Name_____ Date of Birth_____Age_____

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
☐ 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 (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

Snoring and Sleep Apnea Questionnaire Page 3

Name_____ Date of Birth_____Age_____

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 haven't 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*** chance 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 (theater or meeting)	_____
Passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon 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

_____

_____

The above information is accurate to the best of my knowledge. _____ _____
Patient Signature *Date*

I have reviewed the above information with the patient. _____ _____
Physician Signature *Date*

_____
Physician Name (Printed)