



# 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

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

### Previous surgeries

- No  Yes Tonsillectomy \_\_\_\_\_
- No  Yes Adenoidectomy \_\_\_\_\_
- No  Yes Uvulopalatoplasty (UPPP) \_\_\_\_\_
- No  Yes Laser Assisted Uvulopalatoplasty \_\_\_\_\_
- No  Yes Maxillo-mandibular advancement \_\_\_\_\_

### Previous surgeries

- No  Yes Palate implants or injections \_\_\_\_\_
- No  Yes Nasal Septum Surgery \_\_\_\_\_
- No  Yes Sinus Surgery \_\_\_\_\_
- No  Yes Tongue advancement \_\_\_\_\_
- No  Yes Tracheotomy \_\_\_\_\_

### Current Medications (list name, dosage, and frequency)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- 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?

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?**



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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 wakefulness

- |                    |   |   |   |   |   |   |                                       |   |    |
|--------------------|---|---|---|---|---|---|---------------------------------------|---|----|
| 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 |   |    |

### 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

<u>SITUATION</u>	<u>CHANCE OF DOZING</u>
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) \_\_\_\_\_