

## SNORING PATIENT QUESTIONNAIRE

Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Age: \_\_\_\_\_ Date Of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Country of Birth: \_\_\_\_\_

Sex: (circle) Male Female Race: \_\_\_\_\_

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>
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in public	_____
Car passenger (for an hour)	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
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	

**GENERAL HEALTH HISTORY**

PLEASE CIRCLE THE APPROPRIATE ANSWER OR  
 PROVIDE INFORMATION WHERE NECESSARY

Please rate your current health status: poor / average / good / excellent  
 Please rate your current energy level: poor / average / good / excellent  
 Do you currently smoke? Yes / No How long? (years) \_\_\_\_\_ How many packs per day? \_\_\_\_\_  
 Have you smoked in the past? Yes / No When did you stop? \_\_\_\_\_ How many packs per day? \_\_\_\_\_  
 Do you consume alcoholic beverages? ( Beer / Wine / Liquor ) Yes / No  
     How often?           Daily           2-3 week           On weekends           On rare occasions  
 Do you exercise regularly? Yes / No  
     How often?           Daily           2-3 x a week           Rarely  
 Have you GAINED weight over the last 5 years? Yes / No If "Yes", how many lbs? \_\_\_\_\_  
 Have you LOST weight over the last 5 years? Yes / No If "Yes", how many lbs? \_\_\_\_\_

Do you have, or have you had any of the following health problems? (N=no, Y=yes, P=past, C=Current)  
 (Provide additional information below)

N	Y: ( P C )	Cardiac (heart)
N	Y: ( P C )	Blood Pressure
N	Y: ( P C )	Stroke
N	Y: ( P C )	Cancer -- Type _____
N	Y: ( P C )	Pulmonary / Respiratory
N	Y: ( P C )	Diabetes / Hypoglycemia
N	Y: ( P C )	Gastro –Intestinal Problems
N	Y: ( P C )	Bleeding / Blood Clotting Problem
N	Y: ( P C )	Neurologic
N	Y: ( P C )	Psychiatric
N	Y: ( P C )	Thyroid
N	Y: ( P C )	Allergies / Hay Fever / <b>Latex Gloves / Anesthesia</b>
N	Y: ( P C )	Endocrine / Hormonal
N	Y: ( P C )	Nasal Obstruction / Chronic Sinusitis
N	Y: ( P C )	Throat / Voice / Hoarseness
N	Y: ( P C )	Language / Articulation / Resonance
N	Y: ( P C )	Hearing Loss / Balance or dizziness

N Y: ( P C ) Other: \_\_\_\_\_

Are you allergic to any medications? Yes / No

If "Yes", please provide name of medication (s)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking any medication, prescription and/or non-prescription? Yes / No

If "Yes" provide the information below

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Do you use any blood "thinners" such as Coumadin or aspirin? Yes / No (List)

\_\_\_\_\_

Do you use any herbal or "alternative" medications or supplements? Yes / No (List)

\_\_\_\_\_

Do you use any type of "diet" pills? Yes / No (List) \_\_\_\_\_

Are you pregnant or nursing? \_\_\_\_\_

Have you had any surgeries? Yes / No If "Yes", provide the details below:

Surgery: \_\_\_\_\_ Year of Surgery: \_\_\_\_\_

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Surgery: \_\_\_\_\_ Year of Surgery: \_\_\_\_\_

**Thank you for your assistance!**

**For office use only:**

Reviewed: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ M.D. Date: \_\_\_\_\_