EAR, NOSE & THROAT OF LOS GATOS

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Patient Questionnaire for Snoring

Name _____ Occupation _____

Age _____ Height _____ ft _____ inches Weight _____ pounds

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How long have you been snoring? _____

Did your problem start: ☐ Suddenly ☐ Gradually ☐ Intermittently

Are you a vocal performer? ☐ Yes ☐ No

Please rate the following:

Your overall perception of your snoring problem:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Other people's perception of your snoring problem:	☐ None	☐ Mild	☐ Moderate	☐ Severe
The condition of your snoring since it first started:	☐ Absent	☐ Better	☐ No Change	☐ Worse
The effect of your problem on your job:	☐ None	☐ Mild	☐ Moderate	☐ Severe
The effect of your problem on your personal life:	☐ None	☐ Mild	☐ Moderate	☐ Severe
The loudness level or your snoring:	☐ None	☐ Soft	☐ Loud	☐ Very Loud
The extent your snoring bothers others:	☐ None	☐ Mild	☐ Moderate	☐ Severe

Have you ever been evicted from your bedroom because of your snoring? ☐ Yes ☐ No

Have you ever had your bedroom partner leave because of your snoring? ☐ Yes ☐ No

Have you ever been evaluated, diagnosed or treated for snoring or sleep apnea? ☐ Yes ☐ No

When? (month/year) _____

Where? (clinic/institution) _____

By whom? (physician name/speciality) _____

Based on what kind of tests? (explain) _____

Treatment? (describe type) _____

What was the effect? ☐ Worse ☐ No Change ☐ Improved ☐ Cured

Has your weight changed significantly? ☐ Yes ☐ No

If yes, how many pounds? _____ ☐ Gained ☐ Lost

Over what period of time? _____ years _____ months

What time do you go to bed? _____

What time do you awaken in the morning? _____

How long does it take you to fall asleep once in bed? _____ minutes

While waiting to fall asleep do you feel an unsettled or restless sensation in your legs? ☐ Yes ☐ No

Do you kick your legs frequently when you sleep? ☐ Yes ☐ No

Once asleep, how many times do you awaken during the night? _____

Do you know what awakens you? ☐ Yes ☐ No

How long does it take you to fall back asleep? _____

Do you awaken with:	**Dry Mouth?**	☐ Yes	☐ No
	Nasal Congestion?	☐ Yes	☐ No
	Headaches?	☐ Yes	☐ No
	Chest Pain?	☐ Yes	☐ No
Have you ever been observed to have pauses in your breathing while you sleep?		☐ Yes	☐ No
Do you awaken:	**Spontaneously?**	☐ Yes	☐ No
	With an alarm clock?	☐ Yes	☐ No
	Refreshed?	☐ Yes	☐ No
	Fatigued?	☐ Yes	☐ No
Do you consume caffeinated beverages during the day?			
	If yes, how much?	☐ Yes	☐ No
Do you feel sleepy during the day?		☐ Yes	☐ No
Do you take naps during the day or before going to bed?		☐ Yes	☐ No
	If yes, how long? _____		

How likely are you to doze off or fall asleep during the day in the following situations?

	Never	**Slight Chance**	**Moderate Chance**	**High Chance**
Sitting and reading	☐0	☐1	☐2	☐3
Watching TV	☐0	☐1	☐2	☐3
Sitting, inactive in a public place (i.e. theatre)	☐0	☐1	☐2	☐3
As a passenger in a car for an hour without a break	☐0	☐1	☐2	☐3
Lying down to rest in the afternoon when circumstances permit	☐0	☐1	☐2	☐3
Sitting and talking to someone	☐0	☐1	☐2	☐3
Sitting quietly after lunch without alcohol	☐0	☐1	☐2	☐3
In a car, while stopped for a few minutes in traffic	☐0	☐1	☐2	☐3