Patient Sleep Questionnaire

Name: _____ DOB _____.
LAST FIRST

Snoring History:

Please fill out as accurately as possible with assistance from your spouse/ bed partner.

How long have you had problem snoring?		Started recently		Many years
How serious a problem is this for you/spouse?		Mild	Moderate	Severe
Have you seen a specialist for this problem before?		Yes	No	
If so, have you been treated with	CPAP	Yes	No	
	Surgery	Yes	No	
	Dental	Yes	No	
How long does it take you to fall asleep?		Seconds	Minutes	Hours
How many times do you wake up during the night?		0	1-2	3+
Do you/spouse feel you stop breathing at night?		Always	Sometimes	Never
Do you awake suddenly gasping/choking?		Always	Sometimes	Never
Do you feel well rested in the morning?		Always	Sometimes	Never
Do you awake in the morning with a dry mouth?		Always	Sometimes	Never
Do you feel tired during the day?		Always	Sometimes	Never
Do you have trouble breathing through your nose?		Always	Sometimes	Never
Do you have recurring sinus infections?		Often	Sometimes	Never
Do you have frequent facial pressure/pain?		Often	Sometimes	Never
Do you lose your sense of smell?		Often	Sometimes	Never
Do you have headaches?		Often	Sometimes	Never
Do you suffer from heartburn?		Often	Sometimes	Never
Do you have chest pain/discomfort?		Often	Sometimes	Never

EPWORTH SLEEPINESS SCALE:

How likely are you to fall asleep in the following situations, Use the following scale to check the box with 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

Situation	Chance of dozing Please circle one			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting but interactive in a public place e.g. theater or a meeting	0	1	2	3
As a passenger in a car without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes	0	1	2	3

Total score: _____

Is there any thing else you want to tell us?

_____

_____