Smilesketch Boston

SNORING & SLEEP APNEA QUESTIONAIRE

Today's Date _____ Height (feet/inches) _____ Weight (pounds) _____

First Name _____ Last Name _____

Date of Birth _____ Age _____ Gender: ☐ Male ☐ Female

On a scale of 1 to 10, please rate the loudness of your snoring. *(check only one)*

○	○	○	○	○	○	○	○	○	○
1	2	3	4	5	6	7	8	9	10

Mild Moderate Severe

Please complete all questions below.

How long have you been a snorer? _____

☐ Yes ☐ No Has your snoring awakened you?

☐ Yes ☐ No Has your bed partner noted any periods when you stop breathing?

☐ Yes ☐ No Has snoring affected your relationship with your bed partner?

☐ Yes ☐ No Do you feel tired during the day?

☐ Yes ☐ No Do you have morning headaches?

☐ Yes ☐ No Do you have nasal allergies?

☐ Yes ☐ No Do you have restless disturbed sleep?

☐ Yes ☐ No Do you wake up gasping for air?

☐ Yes ☐ No Do you fall asleep at work or while driving?

☐ Yes ☐ No Do you have nasal obstruction (difficulty breathing through your nose)?

If yes, is obstruction: ☐ Constant ☐ Intermittent

Which side do you have obstruction? ☐ Right ☐ Left

Have you ever been diagnosed with any of the following? *(check all that apply)*

☐ Arthritis	☐ Heart Disease	☐ Liver Disease/Hepatitis	☐ Stroke
☐ Cancer/Type _____	☐ High Blood Pressure	☐ MRSA/VRE	☐ Thyroid Disorder
☐ Diabetes Mellitus	☐ High Cholesterol or Lipids	☐ Obstructive Sleep Apnea	☐ Tuberculosis
☐ Eye Conditions	☐ Kidney Disease	☐ Stomach/Intestinal Problems	☐ Ulcers

EPWORTH SLEEPINESS SCALE: Using the scale below, please estimate your risk of falling asleep in the following situations. Even if you have not done these activities recently, try to determine how they have affected you in the past.

0 = No chance of dozing 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (theater or meeting)	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
As a passenger in a car for an hour without a break	
TOTAL	

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____