

Ordering Physician

Todd Berinstein, MD

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ENTOffice.org, PLLC
Sleep and Snoring Questionnaire

PLEASE ANSWER LEGIBLY TO THE BEST OF YOUR KNOWLEDGE

Name _____ Date _____

Height _____ Weight _____

Do you take sleeping pills? Yes No

If yes, what kind? _____

Do you take any kind of medicine that affects your sleep? Yes No

If yes, please list _____

Do you have any of the following? (Requiring medication or hospitalization)

High blood pressure	Yes	No	Heart failure	Yes	No
Irregular heart beat	Yes	No	Thyroid disease	Yes	No
Sleep apnea	Yes	No	Heart valve replacement	Yes	No

Please mark any of the following surgeries you have had:

- | | |
|---|--|
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Adenoidectomy |
| <input type="checkbox"/> Tracheotomy | <input type="checkbox"/> Uvulopalatoplasty (UVP /UVPP) |
| <input type="checkbox"/> Nasal surgery | <input type="checkbox"/> Sinus surgery |
| <input type="checkbox"/> Other oral surgery (list): _____ | |

Please mark problems you are having:

- | | |
|--|---|
| <input type="checkbox"/> Tired all the time | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Restless or disturbed sleep | <input type="checkbox"/> Nasal congestion / obstruction |
| <input type="checkbox"/> Night time waking short of breath | <input type="checkbox"/> Stop breathing in sleep |
| <input type="checkbox"/> Excessive movements in sleep | <input type="checkbox"/> Falling asleep during or after meals |
| <input type="checkbox"/> Falling asleep while driving | <input type="checkbox"/> Recent weight change (+/- ____ lbs) |
| <input type="checkbox"/> Partner sleeps in another room due to noise | |

Have you had a **sleep study**? Yes No

If yes, where? _____

Have you had any previous snoring or sleep treatment? Yes No

If yes, please mark:

- | | |
|--|--|
| <input type="checkbox"/> CPAP | <input type="checkbox"/> Dental Appliance |
| <input type="checkbox"/> UPPP | <input type="checkbox"/> Maxillary Surgery |
| <input type="checkbox"/> Nasal Surgery | <input type="checkbox"/> Pillar |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Other _____ |

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Epworth Sleepiness Scale

Name _____ Date _____

Age (years) _____ Sex: Male Female Other

How likely are you to doze off or fall asleep in the following situations, instead of just feeling tired? This is about your recent and usual way of life.

Even if you have not done some of these things recently, try to think about how they would affect you.

Use the following scale to choose the most appropriate number for each situation:

0	would <i>never</i> doze or sleep
1	<i>slight</i> chance of dozing or sleeping
2	<i>moderate</i> chance of dozing or sleeping
3	<i>high</i> chance of dozing or sleeping

It is important that you answer each question as best as you can.

Situation

Chance of Dozing (0-3)

Sitting and Reading _____	<input type="text"/>
Watching TV _____	<input type="text"/>
Sitting, not active, in a public place (movie theatre or a meeting) _____	<input type="text"/>
Being a passenger in a car for an hour without stopping _____	<input type="text"/>
Lying down in the afternoon _____	<input type="text"/>
Sitting and talking to someone _____	<input type="text"/>
Sitting quietly after a lunch (no alcohol) _____	<input type="text"/>
Stopped for a few minutes in traffic while driving _____	<input type="text"/>

Total: _____