Great Hills ENT Snoring and Sleep Apnea Questionnaire

Mark T. Brown, MD

Name: _____ Date of Birth: _____

Main sleep complaint: _____ Duration: _____

Have you been diagnosed with a sleep disorder? ☐ Yes ☐ No
Do your sleep problems affect your work? ☐ Yes ☐ No
Do your sleep problems affect your home life? ☐ Yes ☐ No
Do you need to take naps? ☐ Yes ☐ No
Do you use caffeine during the day to stay awake? ☐ Yes ☐ No.
If so how much? _____.
How much do you normally sleep? _____ hours
What time do you normally go to sleep? _____ hours

Check all that apply:

☐ Loud snoring ☐ Awakening gasping for air ☐ Difficulty falling asleep
☐ Early awakening ☐ Daytime fatigue ☐ Problems concentrating
☐ Difficulty staying asleep ☐ Work or driving accidents due to sleepiness
☐ Memory problems ☐ Breathing stops when asleep ☐ Fuzzy thinking

Epworth Sleepiness Scale:

This questionnaire helps to measure your general level of daytime sleepiness. Please rate the questions below as best as you can about the chance that you would fall asleep or doze in the situations.

0 = never
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation:

Sitting and reading _____
Watching TV _____
Sitting inactive in a public place (movie theater or meeting) _____
As a car passenger for an hour without a break _____
Lying down to rest in the afternoon _____
Sitting and talking to someone _____
Sitting quietly after lunch (no alcohol) _____
In a car while stopped in traffic _____

Total _____
(Score of >10 indicates excessive daytime sleepiness)

X _____
Signature Date