

# EAR, NOSE AND THROAT ASSOCIATES OF CHESTER COUNTY

## SNORING AND SLEEP APNEA QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First MI

1. How long have you had your sleep problem? \_\_\_\_ weeks/months/years
2. How many nights a week do you have a sleep problem? \_\_\_\_ nights/week
3. Do you have any trouble getting to sleep at night? No \_\_\_\_ Yes \_\_\_\_
4. On the average, how often do you wake up during the night? \_\_\_\_ times/night
5. Are you bothered by waking up too early and not being able to get back to sleep? No \_\_\_\_ Yes \_\_\_\_
6. On the average, how long are you awake in the morning before you finally get up? \_\_\_\_ minutes
7. On the average, how long altogether are you awake during the night? \_\_\_\_ minutes
8. On the average, how long do you actually sleep at night? \_\_\_\_ hours
9. Do you find yourself feeling tired upon awakening after a normal night's sleep? No \_\_\_\_ Yes \_\_\_\_
10. Do you dream? No \_\_\_\_ Yes \_\_\_\_
11. Do you snore? No \_\_\_\_ Yes \_\_\_\_
12. Are you bothered by breathing problems at night? No \_\_\_\_ Yes \_\_\_\_  
If yes, describe: \_\_\_\_\_
13. Do you have any unusual behavior during sleep? No \_\_\_\_ Yes \_\_\_\_  
If yes, describe: \_\_\_\_\_
14. What time do you usually go to bed? \_\_\_\_ a.m. / \_\_\_\_ p.m.
15. What time do you usually get up? \_\_\_\_ a.m. / \_\_\_\_ p.m.
16. Do you usually take naps? No \_\_\_\_ Yes \_\_\_\_ What time? \_\_\_\_\_ How long? \_\_\_\_\_
17. Do you find yourself dozing or catching yourself falling asleep while working? No \_\_\_\_ Yes \_\_\_\_  
while driving a car? No \_\_\_\_ Yes \_\_\_\_
18. For each beverage listed below, write in the average number you drink each day:  
Caffeinated tea \_\_\_\_ cups/glasses/day      Alcoholic beverages \_\_\_\_ glasses/day  
Caffeinated coffee \_\_\_\_ cups/day      Carbonated or caffeinated drinks \_\_\_\_ glasses/day

19. Do you take any kinds of medication or use alcoholic beverages to help you with your sleep?  
No\_\_\_\_ Yes \_\_\_\_ Describe: \_\_\_\_\_
20. Do you smoke or use any nonprescription drugs, including marijuana (many drugs interfere with sleep studies and many yield wrong results)?  
No\_\_\_\_ Yes \_\_\_\_ What and how often? \_\_\_\_\_
21. Do you consider yourself to be in good health? No\_\_\_\_ Yes \_\_\_\_ If no, give details: \_\_\_\_\_  
\_\_\_\_\_
22. Have you experienced (within the past 2 years) weight gain or loss? If yes, give details: \_\_\_\_\_  
\_\_\_\_\_
23. Year of last physical examination: \_\_\_\_\_ Name of physician: \_\_\_\_\_  
Anything found wrong in last physical examination? No\_\_\_\_ Yes \_\_\_\_  
Give details of any abnormal finding: \_\_\_\_\_  
\_\_\_\_\_
24. Do you now see a psychiatrist or a mental health counselor? No\_\_\_\_ Yes \_\_\_\_
25. Are you a professional or semi-professional singer? No\_\_\_\_ Yes \_\_\_\_
26. Do you play a woodwind instrument? No\_\_\_\_ Yes \_\_\_\_
27. Do you speak or use Dutch, Hebrew, or other similar languages? No\_\_\_\_ Yes \_\_\_\_
28. REMARKS: If there are any other aspects of your sleep problem which you feel are important, please describe them in this space or on the back of this sheet:  
\_\_\_\_\_

### EPWORTH SLEEPINESS SCALE

Please indicate the likelihood that you would fall asleep in the following situations (scale of 0-3). This refers to your usual way of life in recent times. Use the following scale to choose 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

<u>SITUATION</u>	<u>CHANCE OF DOZING</u>
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
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	_____