

Name: _____ Account #: _____ Date: _____

**ADVANCED EAR NOSE & THROAT ASSOCIATES
THE ATLANTA SNORING & SLEEP DISORDERS INSTITUTE
SLEEP DISORDER QUESTIONNAIRE**

In order to better understand your sleep problem please answer the following questions. If available, please ask your bed partner or observer for their input. Please mark only one answer for each question. Where appropriate, write in the single best answer that applies.

CHIEF COMPLAINT:

Who referred you to see me? _____

Who is your primary physician? _____

What are the main problems that you are here for? _____

At approximately what age did your sleep problem begin? _____ years old.

Have you had an evaluation for this problem? _____ yes no

Have you been treated (or tried any treatment) for this problem? _____ yes no

If yes, what treatments? _____

Have you had a sleep study? _____ yes no

If yes, when and where? _____

HISTORY OF PRESENT PROBLEM:

	<u>Work Days</u>		<u>Weekends</u>		
Average sleep schedule during the week?	Go to bed at:	am	pm	am	pm
	Get up at:	am	pm	am	pm
How long does it take you to fall asleep at night?		min		min	
On average, how long do you sleep each night?		hours		hours	
How many times do you wake up during the night?		times		times	
At the end of your sleep period, you awaken:		spontaneously		spontaneously	
		alarm clock		alarm clock	
		other		other	
Do you use a snooze alarm?	yes	no	yes	no	
Do you return to bed after arising?	yes	no	yes	no	

What do you ordinarily do just prior to turning out the lights and attempting to go to sleep?
(Reading, TV, Bath, etc.)? _____

Do you take naps? _____ yes no
If yes, about how many times per week? _____ times

What is your present weight? _____ lbs height? _____ neck size? _____ inches

In the last 5 years, has your weight been going up, down, or staying the same? _____
If your weight has changed, by how many pound? _____

Name: _____ Account #: _____ Date: _____

Please mark an X for each symptom.

My family complains about my snoring _____	yes	no
People refuse to share a bedroom because of my snoring _____	yes	no
Loud snoring when sleeping on my back _____	yes	no
Loud snoring when sleeping on my side _____	yes	no
I have been told I stop breathing during sleep _____	yes	no
I have been told I choke or gasp during sleep _____	yes	no
I wake up with a choking or gasping sensation _____	yes	no
I wake up with my heart beating faster than usual _____	yes	no
I wake up feeling frightened _____	yes	no
I wake up frequently during the night _____	yes	no
Unusual movements while asleep _____	yes	no
Profuse sweating during the night _____	yes	no
Nasal congestion, obstruction or discharge at night _____	yes	no
Dry mouth upon awakening _____	yes	no
Headaches upon awakening _____	yes	no
Waking up feeling tired _____	yes	no
Feeling exhausted despite sleeping for many hours _____	yes	no
Unable to get good quality sleep _____	yes	no
Fighting sleepiness during daily activities _____	yes	no
Difficulty staying alert when I am required to _____	yes	no
Falling asleep at the wrong times _____	yes	no
Decreased concentration _____	yes	no
Forgetfulness _____	yes	no
Difficulty getting to sleep _____	yes	no
Taking more than 30 minutes to fall asleep on most nights _____	yes	no
Waking up during the night and having a hard time falling back to sleep _____	yes	no
Waking up early and being unable to fall back asleep _____	yes	no
Need to use sleeping pills _____	yes	no
Unable to sleep at all _____	yes	no
Getting 3-4 hours of sleep on most nights _____	yes	no
Difficulty sleeping away from home _____	yes	no
Creeping crawling sensation of legs before sleep _____	yes	no
Restlessness of legs when lying down in bed before sleep _____	yes	no
Leg twitches during sleep _____	yes	no
Waking up feeling paralyzed and unable to move _____	yes	no
Sudden body weakness brought by strong emotions _____	yes	no
Sudden buckling of the knees brought by strong emotions _____	yes	no
Seeing things when trying to sleep _____	yes	no
Hearing voices or noises when going to sleep _____	yes	no
Talking while asleep _____	yes	no
Walking while asleep _____	yes	no
Eating during the night _____	yes	no
Grinding teeth while asleep _____	yes	no
I often recall my dreams _____	yes	no
Disturbing dreams _____	yes	no

Name: _____ Account #: _____ Date: _____

Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following situations. In contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale and **CHECK** 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			
* Sitting and reading _____	0	1	2	3
* Watching TV _____	0	1	2	3
* Sitting inactive in a public place (e.g., a theater or a meeting) _____	0	1	2	3
* As a passenger in a car for an hour without a break _____	0	1	2	3
* Lying down to rest in the afternoon when circumstances permit _____	0	1	2	3
* Sitting and talking to someone _____	0	1	2	3
* Sitting quietly after a lunch without alcohol _____	0	1	2	3
* In a car, while stopped for a few minutes in traffic _____	0	1	2	3
				Total _____

Have you been in a car accident due to falling asleep at the wheel? _____	yes	no
Have you had a near miss due to falling asleep at the wheel? _____	yes	no
Do you suffer from indigestion? _____	yes	no
Do you awaken with an acid taste in your mouth or throat? _____	yes	no
Do you have to clear your throat frequently? _____	yes	no
Do you have difficulty breathing through your nose? _____	yes	no
If yes, which side: right left both		
Worse during day night both		
Worse any season? _____		
Do you have hayfever (allergies)? _____	yes	no
Do you have problems with itchy nose, runny nose, or itchy eyes? _____	yes	no
Are you troubled by constant coughing? _____	yes	no
Painful or stiff joints? _____	yes	no
Do you suffer from constipation? _____	yes	no
Do you feel cold all the time? _____	yes	no
Do you have problems with very dry skin? _____	yes	no
Are you bothered by periods of depression? _____	yes	no
Does every little thing get on your nerves? _____	yes	no
Do you become suddenly anxious for no good reason? _____	yes	no
Has your shoe size changed recently? _____	yes	no
Has your hand or ring size changed recently? _____	yes	no

Your Occupation: _____

What are your usual working hours? Start: _____ Stop: _____

Are you currently Married, Single, Widowed, or Divorced? _____

Do you have a regular bed partner or observer of your sleep? _____ yes no

Reviewed and accepted into patient history: _____ Date: _____