

# Snoring, Sleep Apnea/Daytime Sleepiness and other Sleep Disorders

## Name:

In your own words, please describe your sleep problem.

When did you first notice it?

Have you had a sleep study? yes no. What is the date of the sleep study?

Have you had a CPAP test with an over night sleep study? yes no What is the date of the CPAP test?

What treatments have been tried?

Were they effective? yes no.

## Level of Fatigue/Sleepiness

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the following scale and indicate the most appropriate number for each situation.

0 - you would never, ever doze

1 - there would be a slight chance of dozing

2 - there would be moderate chance of dozing

3 - there would be a high chance of dozing

Situations:

\_\_\_\_\_ Lying down to rest in the afternoon

\_\_\_\_\_ Sitting and reading

\_\_\_\_\_ Watching TV

\_\_\_\_\_ Sitting, inactive in a public place (e.g., theater, meeting)

\_\_\_\_\_ As a passenger in a car for an hour without a break

\_\_\_\_\_ Sitting and talking to someone

\_\_\_\_\_ Sitting quietly after lunch without alcohol

\_\_\_\_\_ In a car while stopped for a few minutes

**=Total Score**

What time do you go to bed?

What time do you get up?

Do you take naps?

How long?

Are you a shift worker? yes no. What are your hours?

When you wake up, how refreshed are you? Barely Somewhat I feel great

## Insomnia

Do you have trouble falling asleep? yes no.

Do you awaken at night and have trouble falling back asleep? yes no.

How many times a night do you awaken?

What is it that awakens you?

Do you take any medicines to help you get to sleep? yes no.

What do you take?

**Snoring/Sleep Apnea**

Do you snore? yes no. In what positions do you snore? All Back Stomach Right side Left side.

Is your snoring loud enough to awaken yourself? yes no.

Others in the same room? yes no.

Others in adjacent rooms? yes no.

Does this interfere with your bed-partner's sleep? yes no.

**Place a check if you experience any of the following:**

- Snoring interrupted by silence/gasping
- Nighttime sweating
- Grinding/gritting of your teeth at night
- Lack of energy/fatigue
- Heartburn or indigestion
- Talking in your sleep
- Have a restless/tingling feeling in legs at night
- Have a need to move your legs or pace when sitting for an extended period of time during the day
- Feel your knees buckle/arms or jaw feel weak when you laugh or get angry
- Have vivid dream-like episodes or scenes upon awakening or falling asleep that you can't tell if they're real or not.
- Feel paralyzed when waking or falling asleep
- Fall asleep after and emotional event (like laughing)
- Morning headaches
- Memory lapses/difficulty concentrating
- Sore jaws or pain in your ears in morning
- Awaken choking, gasping, or breathless
- Awaken with a sour or bitter taste
- Walking in your sleep
- Repeatedly kick your legs at night

**Body Habitus**

What is your weight now?      lbs. What was it 1 year ago?      lbs.      5 years ago?      lbs.  
In high school?      lbs.

**Nasal Symptoms:** Do you experience any of the following?

- Nasal congestion when lying down constant nasal
- Congestion
- Clear, watery nasal drainage
- Sneezing/itchy eyes, nose, or throat

**Miscellaneous:**

- yes no Do you play any wind/reed/brass instruments?
- yes no Do you speak any languages other than English or Spanish?

Physician:

Date Reviewed: