QUESTIONNAIRE FOR SNORING

Name _____ Age _____ Sex _____ Date _____

THE EPWORTH SLEEPINESS SCALE		
How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? 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 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	**Situation**	**Chance Of Dozing**
	Sitting and reading Watching TV	_____
	Sitting inactive in public place (e.g. theater or meeting)	_____
	As a passenger in a car for an hour without a break	_____
	Lying down to rest in afternoon when circumstances permit	_____
	Sitting and talking to someone	_____
	Sitting quietly after lunch without alcohol	_____
	In car, while stopped for a few minutes in the traffic	_____
	Total Score	_____

THE EPWORTH SLEEPINESS SCALE		
Use the following scale to choose the **most appropriate number** for each situation. 0 = never during a usual night 1 = less than once a week 2 = once to about half the nights per week 3 = half the nights to almost always 4 = almost always or every night ? = don't know or haven't been told	During your usual sleep have you noticed or have been told you do the following:	**(0-4,?)**
	1. Snore loudly	_____
	2. Stop breathing	_____
	3. Choke, struggle for breath	_____
	4. Toss and turn frequently	_____
	5. Wake up with a headache	_____
	Usual number hours of sleep per night	_____
	Number of times your rise to use toilet	_____

Height __ft. _ in Present weight ____lbs. Weight gained in last 12 mos. ___lbs. BMI ___

Have you had an overnight sleep test? Y /N If so, Home ___ or In Lab ___

What other doctors have you seen about your snoring, and what did they advise or do?

_____

_____

_____

_____

(use back if more space needed)

Signature _____ Date _____ Dr Init _____