SNORING AND OBSTRUCTIVE SLEEP APNEA
SCREENING QUESTIONNAIRE

Name:_____Birthdate___/___/___Sex___Ht____Wt_____

Phone Home: _____ Work: _____ Mobile: _____
Street: _____City: _____State:_____
Zip: _____

BEFORE YOU BEGIN: READ ENTIRE QUESTIONNAIRE THIS WILL ASSIST YOU AS YOU PROCEED TO ANSWER THE QUESTIONS

Please use the following guidelines:

Daily= Almost every day or night Often=Two-three times per week
Seldom= Less than once a week Never= Never

SECTION A:

During usual sleep, have you noticed or been told you do the following: (Check one answer in each category)

	Daily	Often	Seldom	Never
A) Snore loudly	_____	_____	_____	_____
B) Choke, struggle for breath or stop breathing	_____	_____	_____	_____
C) Wake because of breathing problem	_____	_____	_____	_____
D) Toss and turn frequently	_____	_____	_____	_____
E) Kick or jerk legs repeatedly	_____	_____	_____	_____

When you wake up after your usual sleep, how often do you experience the following?

	Daily	Often	Seldom	Never
A) Headache	_____	_____	_____	_____
B) Dry mouth	_____	_____	_____	_____
C) Feel tired or unrested	_____	_____	_____	_____

During the time you are usually awake (daytime and evening) how often do you become irresistibly sleepy or fall asleep in the following situations?

	Daily	Often	Seldom	Never
A) After a meal	_____	_____	_____	_____
B) Reading or watching TV	_____	_____	_____	_____
C) At church or school	_____	_____	_____	_____
D) At work	_____	_____	_____	_____
E) While a passenger in a vehicle	_____	_____	_____	_____
F) While driving a vehicle				

Do you have trouble breathing through your nose?

	Daily	Often	Seldom	Never
A) Daytime	_____	_____	_____	_____
B) Night-time in bed	_____	_____	_____	_____

1) How long have you been aware of your snoring? _____
2) Do you have a regular bed partner? Y____ N ____
3) Has snoring caused problems for relatives or friends? Y___ N___
4) Have you been told you stop breathing during your sleep? Y___ N___
5) Have you been told you move around a lot when you sleep? Y___ N___
6) About how many times per night do you wake up? _____
7) Do you have difficulty falling asleep at night? Y___ N___
8) How many hours do you sleep each night? _____

SECTION B:

Do you use any alcoholic beverages or take sedatives?

	Daily	Often	Seldom	Never
A) Daytime	_____	_____	_____	_____
B) Evening shortly before bedtime	_____	_____	_____	_____
C) Does a small amount of alcohol give you a headache?	_____	_____	_____	_____

Have you had or used any of the following:

Nose broken: Y___ N ___ Nasal Surgery: Y___ N___ Tonsillectomy: Y___ N___
Hay fever: Y___ N___ Sinus problems: Y___ N___ Antihistamines: Y___ N___
Cigarettes: Y___ N___ Nasal sprays: Y___ N___ CPAP Machine: Y___ N___

Do you take medications for:

Heart condition: Y___ N___ Respiratory condition: Y___ N___
Thyroid condition: Y___ N___ Metabolism: (weight) Y___ N___

Have you had or done any of the following:

1) Previously seen other Doctors regarding snoring or sleep apnea? Y___ N___
2) Had an overnight sleep lab study? Y___ N___ If so, where _____
3) Gained weight recently? Y___ N___ How much? _____ lbs
4) Do you have a heart problem? Y___ N___ Describe_____
5) Do you have a pacemaker? Y___ N___ How long have you have it? _____
6) Do you have high blood pressure Y___ N___ What is your BP? _____
7) Loss of memory? Y___ N___
8) Depression? Y___ N___
9) Difficult to concentrate? Y___ N___
10) Do your jaw joints click? Y___ N___ Do they lock? Y___ N___
Pain in jaw joint area? Y___ N___
11) Prior injury to head, neck, jaws? Y___ N___ Had Orthodontic treatment? Y___ N___
12) Treated for grinding teeth? Y___ N___ Treated for TMJ? Y___ N___
13) Presently wear a night guard Y___ N___ Wear a full denture? Y___ N___
Wear a partial Y___ N___
14) Presently have most of your natural teeth? Y___ N___

Comments on any items above:

_____

_____

What would be a successful solution to your concern about your snoring and/or sleep apnea?

_____

If you answered YES to at least half of the questions in SECTION A,
You very likely have some level of Obstructive Sleep Apnea.

Call to schedule your consult today! 727.797.5161

NWD Sleep Apnea Solutions

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