Questionnaires for Snoring

Name_____ Age _____ Sex ____ Date _____

Assessment of Daytime Sleepiness (Epworth Sleepiness Scale)

Please complete the questions below. This is a measure of dozing or falling asleep, not just feeling tired. This is to reflect how you have felt most recently. Use the following scale to choose the most appropriate number for each of the situations below:

0 = Would never dose

1 = slight chance of dozing

2 = Moderate chance of dozing

3 = High Chance of dozing.

Chance of dozing (0-3)

Situation	Chance of dozing (0-3)
Sitting and reading	
Watching Television	
Sitting inactive in a public place, for example, a theater or meeting	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (when you've had no alcohol)	
In a car, while stopped in traffic	

SITUATION

Nasal Obstruction Symptom Evaluation (NOSE)

Over the past 1 month, how much of a problem were the following conditions for you?

	Not a problem	Very Mild problem	Moderate problem	Fairly bad problem	Severe problem
Nasal congestion or stuffiness					
Nasal blockage or obstruction					
Trouble breathing through my nose					
Trouble sleeping					
Unable to get enough air through my nose during exercise or exertion					

Visual Analog Scale

Mark on this line how troublesome it is, on average, breathing through your nose.

None_____**Severe**

Behavior During Sleep

Use the following scale to choose the most appropriate number for each situation:	During your usual sleep, you have noticed or have been told you do the following (0-4, ?)
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.	Snore loudly _____ Stop breathing _____ Choke, Struggle for breath _____ Toss and turn frequently _____ Wake up with headache _____

Height _____ ft. _____ inches. Present body weight _____ lbs. Weight gained in the last 12 mos. _____ lbs.

Have you had an overnight sleep test?

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

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Signature _____