



# ENTAA Care

Ear, Nose & Throat, Asthma & Allergy  
Audiology & Hearing Aid Center  
Speech & Balance Center

PATIENT: \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

## SLEEP APNEA AND SNORING

	YES	NO
1. Do you snore?		
2. How long has snoring been a problem? _____		
3. Do you feel well rested when you wake up?		
4. Are you tired during the day?		
5. Do you often fall asleep during the day, at work or while driving?		
6. Do you drink alcohol?		
7. Medications currently taking :		
_____		
_____		
_____		
8. Do you have any of the following medical problems?		
Heart disease		
High Blood Pressure		
Lung Disease		
Stroke		
9. Are you overweight?		
10. Have you had a recent weight gain?		
11. Can you breathe easily through your nose?		
12. Have you ever broken you nose or required surgery on your nose or tonsils?		
13. Have you had any problems with depression or lack of motivation?		
14. Has your snoring or fatigue led to problems in your work or marriage?		
15. Have you developed sexual problems or bed-wetting?		
16. Have you ever been observed to stop breathing during your sleeping?		
17. Other		
Comments _____		
_____		
_____		