ENTAA Care
Ear, Nose & Throat, Asthma & Allergy
Audiology & Hearing Instrument Center
Speech & Balance Center

# SLEEP APNEA AND SNORING

PATIENT: _____

DATE: _____/_____/_____

| | 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 your 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 sleep? | | |
| 17. Other: | | |
| Comments: _____ | | |
| _____ | | |
| _____ | | |

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