Questionnaire for Snoring and Obstructive Sleep Apnea

Name _____ Date _____

Address _____

Phone (Home) _____ (Work) _____ Sex ☐ Male ☐ Female

Age _____ Date of Birth _____ Height _____ Weight _____ Collar Size _____

Occupation _____ ☐ Married ☐ Single

1. What is your reason for coming to the clinic? _____

_____

_____

2. Who referred you to our clinic? _____

3. Have you had an overnight sleep study?
   - ☐ no
   - ☐ yes; when? _____
     Diagnosis:
     - ☐ snoring
     - ☐ sleep apnea
     - ☐ upper airway resistance syndrome
     - ☐ other; please explain _____

For examiner use only:

AHI/RDI: _____

Min. O2 Sat.: _____

4. How long have you been bothered by this problem? _____

5. What is your predominant sleeping position?

   - ☐ Back
   - ☐ Side
   - ☐ Stomach

6. What previous treatment(s) have you tried to correct your problem?
   - ☐ weight loss
   - ☐ changing sleep position
   - ☐ changing pillows
   - ☐ cut back smoking
   - ☐ cut back alcohol
   - ☐ cut back caffeine
   - ☐ Breathe-Rite strips
   - ☐ nasal spray
   - ☐ chin straps
   - ☐ medication
   - ☐ breathing machine (C-PAP; Bi-PAP)
   - ☐ nasal surgery
   - ☐ throat surgery
   - ☐ jaw surgery
   - ☐ oral/dental appliance
   - ☐ other: _____

7. For the following questions, please select the number that best describes your answer:

a. According to your bed partner or other witness, how loud is your snoring?

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Don't snore at all — As loud as could be imagined!

b. According to your bed partner or other witness, do you have times when you suddenly stop snoring and then "gasp and snort"?

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Don't gasp and snort at all — Gasp and snort constantly!

c. How do you usually feel in the morning when you awaken?

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Completely rested and refreshed — Not at all rested and refreshed!

d. How often do you awaken in the morning with a headache?

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Never — Always

e. How tired or sleepy are you during a typical day?

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Not at all sleepy — Extremely sleepy

f. How would you describe the quality of your sleep?

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Very sound and restful — Not sound or restful at all!

8. In the following situations, indicate how likely you are to doze off or fall asleep in contrast to just being tired. This refers to your usual way of life at this time. Use the following scale to choose the most appropriate number for each situation.

0 = would never fall asleep
1 = slight chance of falling asleep
2 = moderate chance of falling asleep
3 = high chance of falling asleep

Situation	Chance of Falling Asleep
Sitting or reading	☐0 ☐1 ☐2 ☐3
Watching TV	☐0 ☐1 ☐2 ☐3
Sitting, inactive in a public place (theater or movie)	☐0 ☐1 ☐2 ☐3
As a passenger in a car for an hour without a break	☐0 ☐1 ☐2 ☐3
Lying down to rest in the afternoon	☐0 ☐1 ☐2 ☐3
Sitting and talking to someone	☐0 ☐1 ☐2 ☐3
Sitting quietly after lunch without alcohol	☐0 ☐1 ☐2 ☐3
In a car while stopped for a few minutes in traffic	☐0 ☐1 ☐2 ☐3
Total	_____

9. Are you aware of, or have you been told that you grind or clench your teeth during sleep?

☐ no
☐ yes

10. Have you ever used, or been told, you need a biteguard for teeth grinding or clenching?

☐ no
☐ yes

11. Check any of the following that you experience:

a. Sounds in the jaw joints:

☐ no (skip to question b.)
☐ yes (if yes, answer the following)

Which side: ☐Right ☐Left ☐Both

Frequency of sounds:
0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
0←occasional constantly present→10

b. Pain in the jaw joints:

☐ no (skip to question c.)
☐ yes (if yes, answer the following)

Which side: ☐Right ☐Left ☐Both

Frequency of pain:
0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
0←Rare constant→10

Severity of pain:
0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
0←very mild very severe→10

c. Pain in the jaw muscles:

☐ no (skip to question d.)
☐ yes (if yes, answer the following)

Which side: ☐Right ☐Left ☐Both

Frequency of pain:
0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
0←Rare constant→10

Severity of pain:
0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
0←very mild very severe→10

d. Difficulty opening your mouth normally:

☐ no (skip to question e.)
☐ yes (if yes, answer the following)

Does pain prevent you from opening your mouth normally?

☐ no
☐ yes

Do you feel that there is a physical blockage in the joint that prevents you from opening your mouth normally?

☐ no
☐ yes

e. Painful or sore teeth:

☐ no
☐ yes

f. Loose teeth:

☐ no
☐ yes

g. Pain or soreness of cheeks or tongue:

☐ no
☐ yes

h. Dry mouth:

☐ no
☐ yes