

Questionnaire for Snoring/Sleep Apnea Patients

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Instructions: Please read each item carefully and answer all questions. For some questions you will be asked to choose one or more answers. If you are asked to provide specific information in writing, use the blank space following the question. If a certain question does not apply to your case, please indicate so by writing 'N/A'.

I. Personal Data

Name: Last _____ First _____ M.I. _____

Home Address: _____

Home Phone: _____ Work Phone: _____

E-mail Address: _____ Sex: (circle) male female

Main Occupation: _____

Additional Occupation: _____

Age: _____ Date of Birth: Month ____/ Day ____/ Year ____ Country of Birth: _____

Race: (circle) Asian Black Caucasian Hispanic Other (specify) _____

Height: _____ ft., _____ in. Weight: _____ lbs. Neck Size: _____

Marital Status: (circle) single engaged married separated divorced widowed

Language(s) Routinely Spoken: (list in order from most used to least used) _____

Are you a vocal performer? yes _____ no _____

If yes, are you a (circle) singer actor announcer clergy other (specify)

II. Background Information

1. Who referred you to this office? (circle) self spouse mate parent(s) child(ren)
friend(s) Physician (specify) _____ other(s) (specify) _____

2. In your own words, describe precisely the nature and severity of your problem, and why you came here

3. How long have you had this problem? _____

4. Did your problem start (circle) suddenly gradually intermittently
other (specify) _____

5. In your opinion, what caused your problem? (explain) _____

6. Explain your treatment goals (what you wish to accomplish after having received medical treatment in this facility). _____

7. On a scale of 1 to 7, where 1 = mild problem, 4 = moderate problem, and 7 = severe problem, please rate *your overall perception of your snoring problem*:

Mild Problem			Moderate Problem			Severe Problem
1	2	3	4	5	6	7

8. On a scale of 1 to 7, where 1 = mild problem, 4 = moderate problem, and 7 = severe problem, please rate *other people's perception of your snoring problem*:

Mild Problem			Moderate Problem			Severe Problem
1	2	3	4	5	6	7

9. On a scale of 1 to 7, where 1 = much worse, 4 = same, and 7 = much better, please rate *the condition of Your snoring since the onset of your first symptoms*:

Much Worse	Moderately Worse	Somewhat Worse	No Change	Somewhat Better	Moderately Better	Much Better
1	2	3	4	5	6	7

10. On a scale of 1 to 7, where 1 = no effect, 3 = mildly negative, 5 = moderately negative, and 7 = extremely negative, please rate the *effect of your problem on your job*:

No Effect		Mildly Negative		Moderately Negative		Extremely Negative
1	2	3	4	5	6	7

11. On a scale of 1 to 7, where 1 = no effect, 3 = mildly negative, 5 = moderately negative, and 7 = extremely negative, please rate the *effect* of your problem on your personal life:

No Effect		Mildly Negative		Moderately Negative		Extremely Negative
1	2	3	4	5	6	7

12. On a scale of 1 to 7, where 1 = extremely soft, 4 = moderately loud, and 7 = extremely loud, please rate the *loudness level* of your snoring:

Extremely Soft			Moderately Loud			Extremely Loud
1	2	3	4	5	6	7

13. On a scale of 1 to 7, where 1 = not bothersome, 3 = mildly bothersome, 5 = moderately bothersome and 7 = extremely bothersome, please rate the extent to which your snoring bothered (or still bothers) another person(s) who share(d) a bed/bedroom with you:

Not Bothersome		Mildly Bothersome		Moderately Bothersome		Extremely Bothersome
1	2	3	4	5	6	7

14. Have you ever:

- a. been 'evicted' from your bed/bedroom/adjacent part of the house because of your snoring?
Yes _____ No _____
- b. lost the companionship of a bed / bedroom partner because of your snoring?
Yes _____ No _____

15. Have you ever been diagnosed with sleep apnea? Yes _____ No _____
 If no, skip to question 18 If yes, when (month/year) _____
 Where? (hospital/institution) _____
 By whom? (physician name/specialty) _____
 Based on what kind of tests? (explain) _____

16. Is your sleep apnea clearly associated with snoring? Yes _____ No _____

17. Have you ever been treated for sleep apnea? Yes _____ No _____
 If yes, when? (month/year) _____ Where? (hospital/institution) _____
 By whom? (physician name/specialty) _____
 How? (describe type and course of treatment) _____

18. Have you ever been treated for snoring? Yes _____ No _____
 If no, skip to question 21
 If yes, when? (month/year) _____ Where? (hospital/institution) _____
 By whom? (physician name/specialty) _____
 How? (describe type and course of treatment) _____

19. On a scale of 1 to 7, where 1 = much worse, 4 = no change, and 7 = much improved, please rate the condition of your snoring problem following snoring treatment.

Much Worse	Moderately Worse	Somewhat Worse	No Change	Somewhat Improved	Moderately Improved	Much Improved
1	2	3	4	5	6	7

20. On a scale of 1 to 7, where 1 = very dissatisfied, 4 = neutral, and 7 = very satisfied, please rate your satisfaction with the snoring treatment you received thus far.

Very Dissatisfied	Moderately Dissatisfied	Somewhat Dissatisfied	Neutral	Somewhat Satisfied	Moderately Satisfied	Much Satisfied
1	2	3	4	5	6	7

21. On a scale of 1 to 7, where 1 = unmotivated, 3 = mildly motivated, 5 = moderately motivated, and 7 = very motivated, please rate the degree of your motivation to alleviate your snoring problem.

Unmotivated		Mildly Motivated		Moderately Motivated		Very Motivated
1	2	3	4	5	6	7

III. General Health History

1. On a scale of 1 to 5, please rate your current health status.

Poor	Fair	Average	Good	Excellent
1	2	3	4	5

2. On a scale of 1 to 5, please rate your current energy level.

Extremely Low	Low	Average	High	Extremely High
1	2	3	4	5

3. Do you currently smoke? Yes _____ No _____
 If no skip to question 4 If yes, how long have you been smoking? _____
 How many per day? _____

4. If you do not smoke now, have you ever smoked? Yes _____ No _____
 If no, skip to question 5 If yes, how long did you smoke? _____
 How many per day? _____
 When did you quit smoking? _____

5. Are you exposed to cigarette smoke?
 At home? Yes _____ No _____
 At work? Yes _____ No _____

6. Do you consume alcoholic beverages? Yes _____ No _____
 If no, skip to question 7 If yes, what types? (specify) _____
 Do you usually drink them:
 a. daily? Yes _____ No _____
 b. two or three a week? Yes _____ No _____
 c. on weekends? Yes _____ No _____
 d. only on rare occasions? Yes _____ No _____
 e. If any of the above, in the evening or before bedtime? Yes _____ No _____

7. Do you take sleep medication, tranquilizers, or other substances to help you 'relax' or fall asleep before bedtime? Yes _____ No _____
 If no skip to question 8 If yes, what types? (specify) _____
 How often? _____

8. Do you exercise? Yes _____ No _____ What type? _____
 How often? _____

9. Have you recently:

- a. Gained weight? Yes _____ No _____
 If yes, over what period of time? _____ years _____ months
 How many pounds? _____ Have you tried to lose it again? Yes _____ No _____
- b. Lost weight? Yes _____ No _____
 If yes, over what period of time? _____ years _____ months
 How many pounds? _____ Did you try to lose it on purpose? Yes _____ No _____
- c. Been on a diet to lose weight? Yes _____ No _____

IV. Miscellaneous

1. On a scale of 0 to 5, please rate the presence/severity of the following symptoms as they apply to you in the present. Please circle one number which best corresponds to your condition.

Symptoms	No Problem	Mild Problem	Moderate Problem			Severe Problem
	0	1	2	3	4	5
difficulty falling asleep	0	1	2	3	4	5
dizzy spells or problems with balance	0	1	2	3	4	5
difficulty staying asleep	0	1	2	3	4	5
tendency to tire quickly (physically weak/easily fatigued)	0	1	2	3	4	5
difficulty waking up (feeling tired/unrested in the morning)	0	1	2	3	4	5
difficulty staying awake during the day	0	1	2	3	4	5
difficulty concentrating	0	1	2	3	4	5
difficulty driving	0	1	2	3	4	5
difficulty remembering things	0	1	2	3	4	5
difficulty staying on task (or following through with projects)	0	1	2	3	4	5
narcolepsy (falling asleep involuntarily during active hours)	0	1	2	3	4	5
difficulty in overall daily functioning	0	1	2	3	4	5
difficulty in moderate physical activity	0	1	2	3	4	5
difficulty/reduction/frustration in sexual activity	0	1	2	3	4	5
difficulty in motor coordination/control	0	1	2	3	4	5
frustration, irritability, impatience or moodiness	0	1	2	3	4	5
tendency to become apathetic, withdrawn, uninvolved	0	1	2	3	4	5
tendency to feel depressed, "down" or sad	0	1	2	3	4	5
tendency to feel unattractive, undesirable, rejected	0	1	2	3	4	5
tendency to respond emotionally, "snap" at people, argue, or overreact to what they say or do	0	1	2	3	4	5
tendency to cry easily or laugh about trivial things	0	1	2	3	4	5
difficulty breathing (shortness of breath) at night	0	1	2	3	4	5
sensation of tightness/fullness in the throat	0	1	2	3	4	5
difficulty breathing through your nose when asleep	0	1	2	3	4	5
sensation of tightness in the chest	0	1	2	3	4	5
difficulty swallowing	0	1	2	3	4	5
suddenly awakening with heart pounding	0	1	2	3	4	5
sensation of pressure or pain in the sternum (middle chest)	0	1	2	3	4	5
tremor (shakiness) in your hand or other body parts	0	1	2	3	4	5
numbness/weakness of arms, legs, or other body parts	0	1	2	3	4	5
sensation of choking/gasping for air during sleep	0	1	2	3	4	5

?(Questionnaire developed by Anat Keidar, Ph.D., CCC-SLP and Yosef P. Krespi, M.D.)