Patient Questionnaire

Patient's Name:_______________________________________Date of Birth: _______________
Phone (home): ____________________(work)__________________ (cell) __________________
Patient's Doctor: ____
Doctor's address: _____________________________________ Phone: _________________
Referring Specialist's Name:______________________________ Phone: _________________

Medical conditions often co-morbid with obstructive sleep apnea. Ask patient if they suffer(ed) from:

Condition	Yes	No
Hypertension/drug resistant hypertension	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
GERD/acid reflux	☐ Yes	☐ No
Heart disease/coronary artery disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No

Snoring and sleep disordered breathing conditions. Ask the patient:

Question	Yes	No
1. Do you snore or have you been told you snore?	☐ Yes	☐ No
2. Do you snore only when you are lying on your back?	☐ Yes	☐ No
3. Do you snore every night?	☐ Yes	☐ No
4. Have you been told you stop breathing or gasp during sleep?	☐ Yes	☐ No
5. Has your partner had to move to another room during the night?	☐ Yes	☐ No
6. Are you currently or have you been treated for high blood pressure?	☐ Yes	☐ No
7. Do you doze off unintentionally during the day?	☐ Yes	☐ No
8. Do you fall asleep when driving?	☐ Yes	☐ No
9. Do you often awaken feeling tired?	☐ Yes	☐ No
10. Do you often awaken with a headache?	☐ Yes	☐ No
11. Do you have problems concentrating for long periods of time?	☐ Yes	☐ No
12. Are you having accidents on the job or at home?	☐ Yes	☐ No
13. Do you feel pain in your jaw joints in the area of the ear?	☐ Yes	☐ No
14. Do you grind or clench your teeth in your sleep?	☐ Yes	☐ No
15. Do you suspect you have sleep apnea?	☐ Yes	☐ No
16. Have you ever been treated for snoring, a sleep disorder, or sleep apnea?	☐ Yes	☐ No
17. Have you ever participated in a sleep study?	☐ Yes	☐ No

- When?_______________ Where?____
  ____
- How is C-PAP working for you? ____

Family History

Question	Yes	No
Have any family members had heart disease/high blood pressure/diabetes?	☐ Yes	☐ No
Do any family members snore, have sleep apnea, or a sleep disorder?	☐ Yes	☐ No

If yes, who? ____

Personal History and Anatomy

Age: ___________________ Weight:___________________ Height: ___________________
Neck circumference: ___________________ Risk factor: Male > 43cm; Female > 41cm
Alcohol consumption (number of drinks per week)___________________
Are there potential obstructions to the airway?
☐ enlarged tonsils ☐ enlarged tongue ☐ enlarged uvula ☐ enlarged adenoids ☐ recessed chin