

SUTTER SLEEP DISORDERS CENTER
Sleep Apnea Questionnaire

Name: _____ Date of Study: _____

Birthday: _____ Age: _____ Height: _____ Weight: _____

Referring Physician: _____ Phone: _____

Address: _____

Primary Physician: _____ Phone: _____

Address: _____

Circle the appropriate answer: If you usually have a sleeping partner it would be most helpful if you complete this questionnaire together.

- I. Do you snore? Yes No
- A. Loudness: Soft Moderate Loud
- B. Is sleeping partner affected: Yes No
- C. Regularity of snoring: 1 2 3 4 5 6 7 nights per week.
Times per night: Few Minutes Few Hours Most of the night All night
- D. How long have you been snoring: _____

- II. Has anyone witnessed apneas while you were sleeping? (Have they seen you stop breathing?)
- A. Who _____
- B. How long in duration: _____
- C. How long: _____
- D. How long have apneas been occurring: _____
- E. Does the chest STOP or CONTINUE moving during apneas.

III. A. Usual sleeping position: Stomach Back Side 1Pillow 2 Pillows Other

IV. Usual bedtime: _____ Usual times you arise: _____

- A. Average number of hours of sleep per night: _____
- B. Average number of hours of sleep per day: _____

V: Please circle the following answers according to the following category.

N – never O – occasional F – frequent C – constant

- | | | | | | |
|-----|--|---|---|---|---|
| 1. | Excessive daytime sleepiness | N | O | F | C |
| 2. | Sweating when asleep | N | O | F | C |
| 3. | Restless sleep / arousals | N | O | F | C |
| 4. | Nighttime shortness of breath | N | O | F | C |
| 5. | Nighttime choking / coughing | N | O | F | C |
| 6. | Night muscle activity / leg kicking, etc | N | O | F | C |
| 7. | Night paralysis | N | O | F | C |
| 8. | Night heartburn | N | O | F | C |
| 9. | Morning headaches / nausea | N | O | F | C |
| 10. | Nightmares/hallucinations | N | O | F | C |
| 11. | Sleep walking | N | O | F | C |
| 12. | Chest pain at night | N | O | F | C |
| 13. | Grind teeth at night | N | O | F | C |

VI. Regular Medications: _____

VII. Allergies: _____

VIII. Diagnosed Respiratory Problem: _____

IX. Abnormal face/neck/throat/nose structure: _____

X. Oral surgeries: _____

XI. Neurological Testing: _____

XII. Neuro Surgeries: _____

XIII. Smoker (if so, how much): _____

XIV. Cardiac Problems: _____

XV. High blood pressure: _____

XVI. Do you feel you have loss of concentration of memory in recent months or years? _____

XVII. Do you feel you have personality changes in recent months or years? _____

XVIII. Employment (type of work): _____

XIX: Previously diagnosed sleep apnea? Yes No

A. Date diagnosed: _____

B. Where diagnosed: _____

C. Treatment: _____

D. Changes since treatment: _____

XIX. Any special problems: _____

XX. What influences have motivated you to seek medical consultation, testing or treatment of your sleep/daytime tiredness concerns? (Check all that apply.)

- | | |
|--|---|
| <input type="checkbox"/> AWAKE (Sleep Apnea Support Group) | <input type="checkbox"/> Primary care physician |
| <input type="checkbox"/> TV/Magazine infomercial | <input type="checkbox"/> Spouse/friend |
| <input type="checkbox"/> Radio AD | <input type="checkbox"/> Employer |
| <input type="checkbox"/> Sutter literature/presentation | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Other _____ | |