SNORING AND OBSTRUCTIVE SLEEP APNEA (OSA) SCREENING QUESTIONNAIRE

Name: _____ **Birthdate** ___/___/___**Sex**___ **Ht**_____ **Wt**_____

BEFORE YOU BEGIN: READ ENTIRE QUESTIONNAIRE, THIS WILL ASSIST YOU AS YOU PROCEED TO ANSWER THE QUESTIONS.

PLEASE USE THE FOLLOWING GUIDELINES:

Daily = Almost every day or night
Often = Two-three times per week
Seldom = Less than once a week
Never = Never

SECTION A:

During usual sleep, have you noticed or been told you do the following:

(Check one answer in each category)	**Daily**	**Often**	**Seldom**	**Never**
A) Snore loudly	_____	_____	_____	_____
B) Choke, struggle for breath or stop breathing	_____	_____	_____	_____
C) Wake because of breathing problem	_____	_____	_____	_____
D) Toss and turn frequently	_____	_____	_____	_____
E) Kick or jerk legs repeatedly	_____	_____	_____	_____

When you wake up after your usual sleep, how often do you experience the following:	**Daily**	**Often**	**Seldom**	**Never**
A) Headache	_____	_____	_____	_____
B) Dry mouth	_____	_____	_____	_____
C) Feel tired or un-rested	_____	_____	_____	_____

During the time you are usually awake (daytime and evening), how often do you become irresistibly sleepy or fall asleep in the following situations:

	Daily	**Often**	**Seldom**	**Never**
A) After a meal	_____	_____	_____	_____
B) Reading or watching TV	_____	_____	_____	_____
C) At church or school	_____	_____	_____	_____
D) At work	_____	_____	_____	_____
E) While a passenger in a vehicle	_____	_____	_____	_____
F) While driving a vehicle	_____	_____	_____	_____

Do you have trouble breathing through your nose?	**Daily**	**Often**	**Seldom**	**Never**
A) Daytime	_____	_____	_____	_____
B) Night-time, in bed	_____	_____	_____	_____

1) How long have you been aware of your snoring? _____
2) Do you have a regular bed-partner? Y___ N___
3) Has snoring caused problems for relatives or friends? Y___ N___
4) Have you been told you stop breathing during your sleep? Y___ N___
5) Have you been told you move around a lot when you sleep? Y___ N___
6) About how many times per night do you wake up? _____
7) Do you have difficulty falling asleep at night? Y___ N___
8) How many hours do you sleep each night? _____

SECTION B:

Do you use any alcoholic beverages or take sedatives?

	Daily	Often	Seldom	Never
A) Daytime	_____	_____	_____	_____
B) Evening, shortly before bedtime	_____	_____	_____	_____
C) Does a small amount of alcohol give you a headache?	_____	_____	_____	_____

Have you had or used any of the following:

Nose broken Y__ N__ Nasal Surgery Y__ N__ Tonsillectomy Y__ N__
Hay fever Y__ N__ Sinus problems Y__ N__ Antihistamines Y__ N__
Cigarettes Y__ N__ Nasal sprays Y__ N__ CPAP Y__ N__

Do you take medications for:

Heart condition Y__ N__ Respiratory condition Y__ N__
Thyroid condition Y__ N__ Metabolism (weight) Y__ N__

Have you had or done any of the following:

1) Previously seen other Doctors regarding snoring or sleep apnea? Y___ N___
2) Had an overnight sleep lab study? Y___ N___ Where_____
3) Gained weight recently? Y___ N___ How much?_____ lbs
4) Do you have a heart problem? Y___ N___ Describe_____
5) Do you have a pace-maker? Y___ N___ How long have you have it? _____
6) Do you have high blood pressure Y___ N___ What is your BP? _____
7) Loss of memory? Y__ N__
8) Depression? Y__ N__
9) Difficult to concentrate? Y___ N___
10) Do your jaw joints click? Y__ N__ Lock? Y__ N__ Pain in jaw-joint area? Y__ N__
11) Prior injury to head, neck, jaws? Y__ N__ Had Orthodontic treatment? Y__ N__
12)Treated for grinding teeth? Y__ N__ Treated for 'TMJ'? Y__ N__
13) Presently wear a 'night guard' Y__ N__ Wear a full denture? Y__ N__ Wear a partial Y__ N__
14) Presently have most of your natural teeth? Y__ N__

Comments on any items above: _____
_____

What would be a 'successful solution' to your concern about your snoring and/or OSA?

_____
_____

☐ **If you answered 'YES' to at least half of the questions in SECTION A, you very likely have some level of Obstructive Sleep Apnea.**