EASTERN OKLAHOMA
EAR, NOSE & THROAT, Inc.

SNORING/SLEEP APNEA QUESTIONNAIRE

Date: _____

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

SSN#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Alternate Contact Name: _____ Phone: _____ Relationship: _____

Age: _____ Sex: ☐ Male ☐ Female

Please answer each of the following questions as completely as you can. These questions will help us evaluate the degree of your snoring problem and the success of your treatment.

1. How bad do you rate your snoring? ☐ Not a problem ☐ Not bad ☐ Bad ☐ Very bad ☐ Extremely bad
2. How bad do other people rate your snoring? ☐ Not a problem ☐ Not bad ☐ Bad ☐ Very bad ☐ Extremely bad
3. Is your snoring getting worse? ☐ Yes ☐ No
4. Does your spouse sleep in the same room that you do? ☐ Yes ☐ No
5. Does your spouse wear earplugs to bed? ☐ Yes ☐ No
6. Do you fall asleep easily? ☐ Yes ☐ No
7. Do you fall asleep while driving? ☐ Yes ☐ No
8. Can people hear you snore in the next room? ☐ Yes ☐ No
9. Do you ever wake up choking? ☐ Yes ☐ No
10. Do you wake yourself up because of your own snoring? ☐ Yes ☐ No
11. Do you fall asleep at work? ☐ Yes ☐ No
12. Have you ever been diagnosed with sleep apnea? ☐ Yes ☐ No
    When? _____
    By whom? _____
13. Have you ever been treated for sleep apnea? ☐ Yes ☐ No
    When? _____
    By whom? _____
    Where? _____
    How were you treated? _____
    _____
14. Have you ever been treated for snoring? ☐ Yes ☐ No
    When? _____

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Mingo Office - 9343 S Mingo Road, Tulsa, OK 74133
(918) 492-3636 · **www.eoent.com**

By whom? _____

Where? _____

How were you treated? _____

_____

15. If you have ever been treated for snoring, has the snoring recurred? ☐ Yes ☐ No
16. Has anyone told you that you stop breathing while you are asleep? ☐ Yes ☐ No
17. Are you tired in the morning when you wake up? ☐ Yes ☐ No
18. Do you have morning headaches when you wake up? ☐ Yes ☐ No
19. Can you breathe through your nose? ☐ Yes ☐ No
20. Do you have allergies or hay fever? ☐ Yes ☐ No
21. Have you ever had a broken nose or nasal surgery? ☐ Yes ☐ No
22. Are you sleepy during the day? ☐ Yes ☐ No

23. Past medical history. Do you or have you had any of the following?

High blood pressure	☐ Yes ☐ No
Heart disease	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No
Irregular heart beat	☐ Yes ☐ No
Heart surgery	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Lung disease	☐ Yes ☐ No
Thyroid disease	☐ Yes ☐ No
Bleeding tendencies	☐ Yes ☐ No
Cancer	☐ Yes ☐ No

Please explain: _____

_____

_____

24. Have you had any previous surgeries? Please list with approximate dates:

_____

_____

_____

25. Do you have any drug allergies? ☐ Yes ☐ No

if yes, please list: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____