Dr. James D. Lund DDS

QUESTIONAIRE FOR SNORING AND/OR SLEEP APNEA

Name:_____Date:_____Date of Birth_____

Age:_____ Sex: M F Weight:_____Height:_____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations in contrast to feeling just tired? This refers to your usual way of of life within the past year. Even if you have not done some of these things recently, try to think of how you would have responded to them. Use the following scale to choose the most appropriate number for each situation.

0 -Would never doze
1 –Slight chance of dozing
2 –Moderate chance of dozing
3 –High chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (ie, Theatre, Church, Meetings)	_____
As a passenger in a car for one hour	_____
Lying down to rest in the afternoon	_____
Sitting and talking to a friend or business collegue	_____
Sitting quietly after lunch (no alcohol)	_____
In a car while stopped for a few moments in traffic	_____

PATIENT SCORE _____
TOTAL POSSIBLE SCORE = 24

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DURING SLEEP

How many hours of sleep to you get each night? (on average) _____
Do you dream? _____
Do you snore loudly? _____
Do you stop breathing? _____
Do you choke or struggle for breath? _____
Do you toss and turn frequently? _____
Do you grind your teeth? _____
Do you awaken with a headache? _____
Do you have morning fatigue, fogginess? _____
Do you awaken feeling unrefreshed or tired? _____

Weight lost or gained in last 12 months _____lbs.

Do you use alcohol or sleeping pills prior to sleeping?_____

Have you ever had an overnight sleep study (polysomnogram)?_____

Do you feel that your situation is serious?_____

What other doctors have you seen about your snoring and/or sleep apnea and what did they advise?

_____
_____
_____
_____