Lawrence Otolaryngology Associates, LLC
Sleep Apnea Questionnaire
Dr. Robert Dinsdale

NAME_____ DATE _____

So we may better understand your symptoms, please answer these questions:

1) Do you usually feel well-rested after sleeping? Yes / No
2) When do you usually go to bed? _____PM/AM
3) When do you usually get up? _____AM/PM
4) If you do not have to get up, how late will you sleep? _____AM/PM
5) Do you work nights? Yes / No
6) What was your weight at the end of high school? _____LBS
7) What was your weight 5 years ago? _____LBS
8) What is your current weight? _____LBS
9) Has anyone in your extended family (parents, brothers/sisters, uncles/aunts, grandparents) snored loudly or had sleep apnea? Yes / No
10) Has anyone in your extended family had a heart attack before age 60, sudden death before age 60, or unexplained car wrecks? Yes / No
11) Please help us get an idea of your sleepiness using the scale below:

Tell us how likely you are to doze off or fall asleep in the following situations. Think of how likely this has been in the last year in normal, everyday life. List the chance of actually sleeping or dozing, not just feeling tired. Even if you have not had some of these situations lately, imagine how they would have affected you.

0 = would **never** doze
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

SITUATION	**CHANCE OF DOZING**
1) Sitting and reading	_____
2) Watching television	_____
3) Sitting inactive in a public place (theater, meeting, etc)	_____
4) As a passenger in a car for an hour without a break	_____
5) Lying down to rest in the afternoon when circumstances permit	_____
6) Sitting and talking to someone	_____
7) Sitting quietly after lunch (without alcohol)	_____
8) In a car, while stopped, for a few minutes in traffic	_____