

Expanded Sleep, Snoring and Apnea History Questionnaire:

These terms refer to medical conditions which have serious health consequences. Sleep apnea is characterized by stoppage, disruption, or ineffective breathing, while sleeping. This condition deprives the brain and other vital organs of oxygen and causes stresses linked to high blood pressure, heart attacks, strokes, diabetes, and even death. Ineffective breathing and obstructive breathing can also affect children, impairing physical, intellectual, and emotional development. Undiagnosed sleep apnea and breathing disorders affects length and quality of life. Please take time to carefully answer the following questions so we may more accurately rule out the probability of this affecting you and your loved ones.

Check answer box and elaborate if yes.

1. Yes No Do you become easily fatigued? What time of day? _____
2. Yes No Do you have problems with insomnia? _____
3. Yes No Do you sleep well? How long? _____
4. Yes No Do you dream? How often? _____
5. Yes No Do you have trouble falling asleep or staying asleep? Which? _____
6. Yes No Do you snore or have you been told you snore? _____
7. Yes No Do you wake up with a headache? _____
8. Yes No Have you had unexplained chronic sleepiness, fatigue, or weariness? _____
9. Yes No Do you often fall asleep reading or watching television? _____
10. Yes No Have you fallen asleep against your will during the day? _____
11. Yes No Do you find yourself irritable or short tempered? _____
12. Yes No Have you felt that your memory and/or intellect is impaired? _____
13. Yes No Have you ever been told that you stop breathing while asleep? _____
14. About how many times a night do you wake up? _____
15. What time do you normally go to bed? _____ Get up? _____
16. Of the hours in bed, how many hours are you asleep? _____
17. How would you rate your quality of sleep? Good?__ Fair?__ Poor?__
18. Yes No Do you have difficulty breathing through your nose? _____
19. Yes No Any family members been diagnosed or treated for sleep disorder? _____
20. Yes No Have you received a professional sleep evaluation for sleep apnea, snoring, or sleep breathing disorder? _____

I certify that the above information is correct to the best of my knowledge and understand the treatment options, risks and consequences of Sleep Apnea and Sleep Breathing Disorder.

Patient/Guardian Signature _____ Date _____