DALLAS ENT GROUP

Adult and Pediatric Otolaryngology
12720 Hillcrest Rd, Suite 900
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Phone 972-566-8300
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Sleep Questionnaire

Name:_____ Date:_____

DOB:_____ Sex:_____ Height:_____Weight:_____ Neck Size:_____

Chief Complaint: (Check one)

☐ Snoring ☐ Sleepiness/Fatigue ☐ Other:_____

Snoring

1. Do you snore no matter what position you are lying in? (Check One) Yes No Do Not Know
2. Do you snore every night? (Check One) Yes No Do Not Know
3. Is your snoring interrupted by pauses and/or choking sounds? (Check One) Yes No Do Not Know
4. Has your sleep mate ever commented on your snoring? (Check One) Yes No N/A
5. Do you "grind" your teeth at night? (Check One) Yes No Do Not Know
6. Do you have high blood pressure? (Check One) Yes No Do Not Know
7. On a scale from 1-10, with 10 being the loudest, how loud is your snoring? _____
8. Other comments:_____
   _____

Sleepiness/Fatigue

1. How would you describe yourself? (Check all that apply)

   ☐ Fatigued ☐ Sleepy ☐ Tired ☐ Other:_____

2. What tasks or activities have you eliminated or find difficulty in completing?

   _____

   _____

3. What is your energy level on a scale of 1-10? (Check one)

   No energy ← 1 2 3 4 5 6 7 8 9 10 → Very high energy

4. Other comments:_____

   _____

Sleep

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1. Around what time to you usually fall asleep? _____
2. Around what time to you usually wake up?_____
3. Is it difficult to fall back asleep if you wake up during the night? (Check one) ☐ Yes ☐ No
4. How often do you wake up during the night (bathroom, clock, noises, etc…)?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently
5. What is the quality of your sleep on a scale from 1 to 10? (Check one)
   Very Poor ← 1 2 3 4 5 6 7 8 9 10 → Excellent
6. Other comments:_____

Other Symptoms (check all that apply)

☐ Allergies ☐ Impotence ☐ Sore throat ☐ Reflux
☐ Depression ☐ Recent weight gain ☐ Teeth grinding ☐ Headache

History

1. Have you ever been treated for your snoring or sleep disorder? (Circle one)
   ☐ Yes ☐ No ☐ Do Not Know
2. If Yes, please fill out the following:
   Provider Name:_____ Provider Phone Number: _____
   Provider Address: _____
   Date of the evaluation:_____
   Diagnosis:_____
   Describe any treatment that you may have received and the success and/or failure you experienced._____
   _____
   _____