

DEBORAH J. FREEHLING, M.D., INC.

Board Certified

Ear Nose & Throat · Allergy · Head & Neck Surgery · Facial Plastic Surgery

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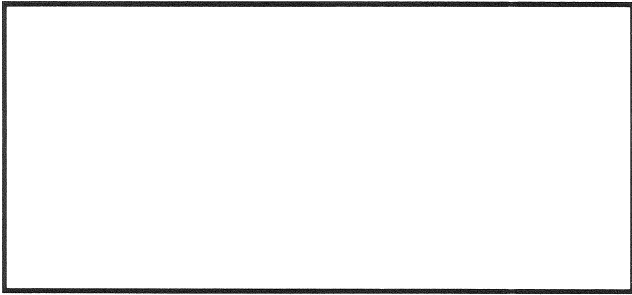
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SNORING/SLEEP APNEA QUESTIONNAIRE

NAME: _____ AGE: _____ SEX: _____ DATE: _____

HEIGHT: _____ WEIGHT: _____ WEIGHT ONE YEAR AGO: _____

1. DO YOU SNORE? YES _____ NO _____
How long have you been snoring? _____
How has your snoring been described? LOUD _____ SOFT _____ CONSTANT _____
OTHER _____
Do you snore on your back? _____ (R) side? _____ (L) side? _____
2. DO YOU MOUTHBREATHE DURING SLEEP? YES _____ NO _____ MAYBE _____
AT TIMES _____
3. HAVE YOU BEEN TOLD THAT YOU STOP BREATHING (HAVE APNEA) DURING SLEEP?
YES _____ NO _____
4. DO YOU THINK YOU MIGHT HAVE APNEA DURING SLEEP? YES _____ NO _____
MAYBE _____
5. DO YOU WAKE UP AT NIGHT? YES _____ NO _____
How long have you been doing this? _____
To urinate? _____
How many times usually? _____
For what other reasons? _____
How many times usually? _____
Does your heart beat quickly when you wake at night? _____
6. ARE YOU SLEEPY DURING THE DAY? YES _____ NO _____
How long have you been feeling sleepy during the day? _____
Do you take naps? _____
How often? _____
Do you fall asleep during the day? _____
When? _____
7. WHAT TIME DO YOU USUALLY GO TO BED? _____
8. WHAT TIME DO YOU USUALLY WAKE UP? _____
9. WHAT TIME DO YOU USUALLY GET OUT OF BED? _____
10. WHAT PERCENTAGE OF THE TIME DO YOU FEEL REFRESHED OR TIRED IN THE MORNING? _____
11. DO YOU DRINK CAFFEINATED BEVERAGES (COFFEE, TEA, COLA) UPON AWAKENING?
YES _____ NO _____
How many cups per day? _____



EPWORTH SLEEPINESS SCALE

Please indicate the likelihood that you would fall asleep in the following situations (scale of 0-3). This refers to your usual way of life in recent times. 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 (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Total

Thank you for your cooperation

Understanding the Diagnosis and Treatment of Obstructive Sleep Apnea

Berlin Questionnaire

Category 1

1. Do you snore?
 - As loud as breathing
 - As loud as talking
 - Louder than talking
 - Loud enough to be heard in the next room
2. How often do you snore?
 - Nearly every day
 - 3-4 x /week
 - 1-2 x /week
 - 1-2 x /month
 - Hardly ever
3. Has your snoring ever bothered other people?
 - Nearly every day
 - 3-4 x /week
 - 1-2 x /week
 - 1-2 x /month
 - Hardly ever
4. Has anyone noticed you stop breathing when you are asleep?
 - Nearly every day
 - 3-4 x /week
 - 1-2 x /week
 - 1-2 x /month
 - Hardly ever

Category 1 is positive if any of the above is present.

Category 2

1. After sleep, are you fatigued?
 - 3-4 x /week
 - 1-2 x /week
 - 1-2 x /month
 - Hardly ever
2. While awake, are you fatigued?
 - 3-4 x /week
 - 1-2 x /week
 - 1-2 x /month
 - Hardly ever
3. Have you ever fallen asleep while driving a vehicle?
 - Nearly every day
 - 3-4 x /week
 - 1-2 x /week
 - 1-2 x /month
 - Hardly ever

Category 2 is positive if any of the above is present.

Category 3

1. Do you have hypertension?
2. Is your BMI > 30?

Category 3 is positive if any of the above is present.

If ≥ 2 categories are positive, high risk for sleep disorder.