



THE NEW YORK OTOLARYNGOLOGY
GROUP, P.C.

The Ear, Nose and Throat Specialists

Name _____ DOB ____/____/____ Age _____

DO I HAVE SLEEP APNEA?

If you have not filled out this form before, please check the symptoms that best describe your condition(s). If you are experiencing two or more symptoms, please tell your doctor.

	<u>ALWAYS</u>	<u>FREQUENT</u>	<u>RARE</u>
Restless Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loud, heavy snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased daytime alertness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability, short temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood or behavior changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety or depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased interest in sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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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 life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to select the *most appropriate number for each situation*:

- | | |
|--------------------------------------|-----------------------------|
| 0 = I would <i>never</i> doze | 1 = <i>slight</i> chance of |
| 2 = <i>Moderate</i> chance of dozing | 3 = <i>chance</i> of dozing |

SITUATION **CHANCE OF DOZING**

- | | |
|---|-------|
| Sitting and reading | _____ |
| Watching TV | _____ |
| Sitting inactive in a public place (e.g. theatre or 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 with alcohol | _____ |
| In a car, while stopped for a few minutes in traffic | _____ |

TOTAL _____

Are you bothered by sleepiness under other circumstances? YES NO

If YES, please describe:

Have you been in a car accident due to falling asleep at the wheel? YES NO
 NEAR-MISS

If YES, please describe:

Have you had other types of accidents because of sleepiness? YES NO

If YES, please describe:



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GENERAL MEDICAL HISTORY

What is your present weight? _____ lbs. and height _____?

What is your neck size? _____

Excluding pregnancy, what has the range of your weight been over the past five years?

Least weight _____ lbs Most weight _____ lbs

What change has there been in your weight in the last five years? _____

Please check below if you have had any previous treatment for the following:

___ Nasal/Sinus Surgery ___ Tonsillectomy ___ Oral Surgery
___ Somnoplsty, Laser, Palatel Stiffening Procedure ___ UPPP

Are you currently using a CPAP device? Or have you used one in the past?

___ YES ___ NO

What is your occupation? _____

What are your working hours? Start _____ AM/PM End _____ AM/PM

How long have you been on this work scheduled? _____

Which of these best describes the extent of physical labor your present job or lifestyle demands?

___ Low -Main job done at desk or sitting with little or no physical activity.
Lifestyle with little physical activity (no regular exercise program & daily activities without much physical effort)

___ Moderate -Lifestyle or main activity of job involves moderate work
(standing, reaching, walking, etc.)

___ High -Lifestyle or main activity of job involves strenuous work (heavy
equipment, loading, climbing, etc.)