ENT Oregon Ear, Nose & Throat Center
541-779-7331

Name: _____ DOB: _____ Age: _____ Date: _____

Gender: ☐ Male ☐ Female Neck size: _____ Weight one year ago: _____ Weight five years ago: _____

Current weight: _____ Height: _____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

PREVIOUS SURGERIES

☐ No ☐ Yes Tonsillectomy
☐ No ☐ Yes Adenoidectomy
☐ No ☐ Yes Uvulopalatoplasty (UPPP)
☐ No ☐ Yes Laser assisted UPPP
☐ No ☐ Yes Maxillo-mandibular advancement
☐ No ☐ Yes Palate implants or injections
☐ No ☐ Yes Nasal septum surgery
☐ No ☐ Yes Sinus surgery
☐ No ☐ Yes Tongue advancement
☐ No ☐ Yes Tracheotomy

MEDICAL HISTORY

☐ No ☐ Yes Irregular rhythm or pulse
☐ No ☐ Yes Congestive heart failure
☐ No ☐ Yes High blood pressure
☐ No ☐ Yes Sleep apnea
☐ No ☐ Yes Pacemaker
☐ No ☐ Yes Thyroid problems
☐ No ☐ Yes Asthma
☐ No ☐ Yes Sinusitis
☐ No ☐ Yes Diabetes
☐ No ☐ Yes Other: _____
☐ No ☐ Yes Do you smoke? How much and for how long? _____
☐ No ☐ Yes Do you drink alcohol? How much? _____
☐ No ☐ Yes Have you gained weight recently? How much? _____
☐ No ☐ Yes Have you lost weight recently? How much? _____
☐ No ☐ Yes Do you exercise? ☐ Rarely ☐ Monthly ☐ Weekly ☐ Several times a week ☐ Daily
☐ No ☐ Yes Diagnosed with sleep apnea? When? _____ by which practitioner? _____
☐ No ☐ Yes Have you ever had a polysomnogram (sleep study)?
If yes, please bring a copy of this test to your appointment.
☐ No ☐ Yes Have you ever used (please circle) CPAP or BIPAP How long? _____
☐ No ☐ Yes Have you ever been evicted from your bed or bedroom because of your snoring?
☐ No ☐ Yes Has your companion ever moved to another room because of your snoring?
☐ No ☐ Yes Are you able to share a hotel room with a travel companion or do you snore too loud?

DO YOU SNORE WHILE SLEEPING ON YOUR:

☐ No ☐ Yes Back
☐ No ☐ Yes Stomach
☐ No ☐ Yes Side
☐ No ☐ Yes Do you have difficulty waking up in the morning
☐ No ☐ Yes Difficulty staying awake while driving

Name: _____ DOB: _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING:

☐ No ☐ Yes Difficulty with your memory
☐ No ☐ Yes Difficulty breathing through your nose
☐ No ☐ Yes Mouth breathing at night (dry mouth in the morning)
☐ No ☐ Yes Excessive movements during sleep
☐ No ☐ Yes Wake up during the night gasping for air
☐ No ☐ Yes Wake up with your heart pounding
☐ No ☐ Yes Any observed periods at night when you stop breathing?

Evaluation of snoring as reported by bed partner (please circle one):

1	2	3	4	5	6	7	8	9	10

1-3 **Occasional soft snoring** – not bothersome to bed partner
4-6 **Persistent snoring** – bothersome to bed partner
7-9 **Persistent loud snoring** – frequently annoying to bed partner
10 **Heroic snoring** – continuous, loud snoring not tolerated by bed partner

Rate your morning alertness or wakefulness

1	2	3	4	5	6	7	8	9	10

Very alert, rested — Very hard to get up, still very tired

Rate your job performance or alertness

1	2	3	4	5	6	7	8	9	10

Very alert, never nod off — Very hard to concentrate more than five minutes, frequently nod off if not active

Name: _____ DOB: _____

SLEEPINESS SURVEY

How likely are you to doze off or fall asleep in the following situations? This refers to your usual lifestyle recently. If you haven't done a certain activity recently, imagine how likely you would be to fall asleep. Choose the **most appropriate number** from the following scale 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 television	
Sitting, inactive in a public place (theatre or meeting)	
Passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting quietly after a lunch without alcohol	
Sitting and talking with someone	
In a car, while stopped for a few minutes in traffic	

COMMENTS OR OTHER INFORMATION NOT INCLUDED ABOVE

Information provided is accurate to the best of my knowledge.

x _____ x _____

Patient/Legal Representative Signature Date

I have reviewed this document with the patient or their legal representative.

x _____ x _____

Physician Signature Date

x _____

Physician Name (Printed)