BLACKSTONE MEDICAL SERVICES
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SNORING AND OBSTRUCTIVE SLEEP APNEA (OSA)
SCREENING QUESTIONNAIRE

Name: _____ Birthdate __/__/__Sex__ Ht___ Wt_____
Phone: home ____/____-____ wk____/____-_____ cell __/____-__ _____
Street_____City_____State_____Zip_____

BEFORE YOU BEGIN: READ ENTIRE QUESTIONNAIRE
THIS WILL ASSIST YOU AS YOU PROCEED TO ANSWER THE QUESTIONS.

Please use the following guidelines:
Daily = Almost every day or night **Often =** Two-three times per week
Seldom = Less than once a week **Never =** Never

SECTION A:
During usual sleep, have you noticed or been told you do the following:
(Check one answer in each category)

	Daily	Often	Seldom	Never
A) Snore loudly	____	____	____	____
B) Choke, struggle for breath or stop breathing	____	____	____	____
C) Wake because of breathing problem	____	____	____	____
D) Toss and turn frequently	____	____	____	____
E) Kick or jerk legs repeatedly	____	____	____	____

When you wake up after your usual sleep, how often do you experience the following:

	Daily	Often	Seldom	Never
A) Headache	____	____	____	____
B) Dry mouth	____	____	____	____
C) Feel tired or un-rested	____	____	____	____

During the time you are usually awake (daytime and evening), how often do you become irresistibly sleepy or fall asleep in the following situations:

	Daily	Often	Seldom	Never
A) After a meal	____	____	____	____
B) Reading or watching TV	____	____	____	____
C) At church or school	____	____	____	____
D) At work	____	____	____	____
E) While a passenger in a vehicle	____	____	____	____
F) While driving a vehicle	____	____	____	____

Do you have trouble breathing through your nose?

	Daily	Often	Seldom	Never
A) Daytime	____	____	____	____
B) Night-time, in bed	____	____	____	____

1) How long have you been aware of your snoring? _____
2) Do you have a regular bed-partner? Y___ N___
3) Has snoring caused problems for relatives or friends? Y___ N___
4) Have you been told you stop breathing during your sleep? Y___ N___
5) Have you been told you move around a lot when you sleep? Y___ N___
6) About how many times per night do you wake up? _____
7) Do you have difficulty falling asleep at night? Y___ N___
8) How many hours do you sleep each night? _____

SECTION B:
Do you use any alcoholic beverages or take sedatives?

	Daily	Often	Seldom	Never
A) Daytime	_____	_____	_____	_____
B) Evening, shortly before bedtime	_____	_____	_____	_____
C) Does a small amount of alcohol give you a headache?	_____	_____	_____	_____

Have you had or used any of the following:

Nose broken Y__ N__ Nasal Surgery Y__ N__ Tonsillectomy Y__ N__
Hay fever Y__ N__ Sinus problems Y__ N__ Antihistamines Y__ N__
Cigarettes Y__ N__ Nasal sprays Y__ N__ CPAP Y__ N__
Do you take medications for:
Heart condition Y__ N__ Respiratory condition Y__ N__
Thyroid condition Y__ N__ Metabolism (weight) Y__ N__
Have you had or done any of the following:

1) Previously seen other Doctors regarding snoring or sleep apnea? Y___ N___
2) Had an overnight sleep lab study? Y___ N___ Where_____
3) Gained weight recently? Y___ N___ How much?_____lbs
4) Do you have a heart problem? Y___ N___ Describe_____
5) Do you have a pace-maker? Y___ N___ How long have you have it? _____
6) Do you have high blood pressure Y___ N___ What is your BP? _____
7) Loss of memory? Y__ N__
8) Depression? Y__ N__
9) Difficult to concentrate? Y___ N___
10) Do your jaw joints click? Y__ N__ Lock? Y__ N__ Pain in jaw-joint area? Y__ N__
11) Prior injury to head, neck, jaws? Y__ N__ Had Orthodontic treatment? Y__ N__
12)Treated for grinding teeth? Y__ N__ Treated for 'TMJ'? Y__ N__
13) Presently wear a 'night guard' Y__ N__ Wear a full denture? Y__ N__ Wear a partial Y__ N__
14) Presently have most of your natural teeth? Y__ N__
Comments on any items above: _____
_____
What would be a 'successful solution' to your concern about your snoring and/or OSA?_____
_____
If you answered 'YES' to at least half of the questions in SECTION A, you very likely have some level of Obstructive Sleep Apnea.

Should you desire to discuss further treatment options please either email or contact us. A quick telephone call just might be your first step to a better 'quality of life'. Please Contact us at 813-831-2727