Name_____________________________________________     Date____________________
Fill out with the help of your spouse or relative – if applicable.
1.  My snoring is:
   ____ Very loud every night, all night
   ____ Every night, not constant, not always loud
   ____ Occasional/mild
   ____ I Never/ or almost never snore
2.  Do you and your spouse commonly sleep in different rooms due to snoring?  ____Yes   ____No
3.  What percent of the night do you sleep on your back? ________
4.  Has anyone noted pauses in your breathing (apnea) during sleep?  ____Yes   ____No
   (Check one) If yes:
   ____ Repetitively, all night, every night
   ____ Some pauses of breathing (apnea) every night
   ____ Occasional pauses of breathing (apnea), not every night
5.  Do you awaken with a headache?  ____ Sometimes
   ____ Commonly
   ____ No
6.  Do you nap daily?               ____ Yes   ____ No
7.  How likely are you to dose off or fall asleep in the following situations, in contrast to feeling just tired? Think about these situations in your day to day life in the past 6 months. Even if you have not been in some of these situations recently, think about how they might have affected you in the past. Use the following scale to choose the most appropriate number for each situation:

   Scale:
   0 = Would never dose
   1 = Slight chance of dozing
   2 = Moderate chance of dozing
   3 = High chance of dozing

   Situation
   Sitting and reading
   Watching TV
   Sitting, inactive in a public place (e.g., a theatre or a meeting)
   As a passenger in a car for an hour without 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 the traffic

8.  On a scale of 1 – 10 (1 not being tired at all and 10 being exhausted during the day), what number would best describe your average daytime tiredness or sleepiness? ________________
9.  Driving:  ____Yes  ____No  Do you often get drowsy?  
____Yes  ____No  Have you occasionally nodded off or closed your eyes for a fraction of a second? 
____Yes  ____No  Have you drifted out of your lane from dozing? 
____Yes  ____No  Have you had a car accident from falling asleep?

10. Have you ever had a significant nasal injury (sports activities, fist fights, opening door, etc.)?  ___Yes   ____No

11. Do you have nasal allergies/hay fever?  ____Yes   ____No

12. Do you sometimes awaken with one nostril or the other plugged up?  ____Yes   ____No

13. What is your present weight?  _______lbs.   5 years ago?_______lbs.   10 years ago?_______lbs.

14. Have you ever had a thyroid function blood test?  ____Yes   ____No

15. How many hours, on the average, do you sleep per night?  _____hrs

16. What is your usual bedtime?  _______     Usual awakening time?  _______

17. How many additional awakenings do you have on an average night?  _______

   What awakens you?  (Check all that apply):
   ____Need to void (urinate) 
   ____Shortness of breath 
   ____Noise of snoring 
   ____Don't know 
   ____Other________________________________________________
   ____Not applicable to me 

   Do you have difficulty falling back to sleep?  
   ____Yes   ____No

18. Do your legs twitch as you are drifting off to sleep?  ____Yes   ____No

19. Do you need to get up and walk to stretch and move your legs at night?  ____Yes   ____No

20. Do you have heartburn or acid taste in your throat at night?  ____Always   ____Sometimes   ____Never

21. Have you heard a voice speaking or seen things like visions or dreams, as you fall asleep or upon awakening? 
   ____Yes   ____No

22. Have you felt paralyzed or unable to move, though mentally alert, as you fall asleep or upon awakening? 
   ____Yes   ____No

23. Have you had episodes of instant muscle weakness (knees buckle, jaw drops, falls, near falls, or voice slurs) brought on by laughter, humor, anger or excitement?  _____Yes   _____No

Continue to page 3
24. What is your average number of cups per day of:  Coffee/tea______  
                                 Cola drinks______  
                           Alcohol______  

25. Do you take at night:  ____Yes   ____No  Sedative/nerve pills?  
                                 ____Yes   ____No  Sleeping pills?  
                                 ____Yes   ____No  Antidepressant pills?  

26. Do you exercise regularly?  ____Yes   ____No  
                                      What form of exercise?_________________________________________  
                                      Minutes per day________  
                                      TIMES per week________  

**Family History**  
Check if any blood relative has or has had any of the following:  

_____ Stroke  _____ Emphysema  _____ Loud snoring  
_____ High blood pressure  _____ Lung cancer  _____ Sleep apnea  
_____ Diabetes  _____ Heart disease  _____ Restless leg syndrome  
_____ Asthma  _____ Narcolepsy  

**Past History (personal)**  
Have you had any of the following illnesses?  (Check all that apply)  

_____ Angina pectoris  _____ Frequent lung infections  _____ Stomach ulcers  
_____ Heart attack  _____ Emphysema  _____ Hepatitis  
_____ Other heart disease  _____ Diabetes  _____ Colitis  
_____ High blood pressure  _____ Cancer  _____ Arthritis  
_____ Kidney disease  _____ Frequent bladder infections  _____ Depression  
_____ Hay fever  _____ Nervous breakdown  _____ Suicidal thoughts or attempts  
_____ Asthma  _____ Thyroid disease  _____ Other:__________________  

**Operations, Hospitalizations, and Serious Injuries:**  
List and indicate approximate year  

______________________________________________  
______________________________________________  
______________________________________________  
______________________________________________  
______________________________________________  
______________________________________________  

Are you allergic to any medications?  ____Yes   ____No  
If yes, please list medications and the reaction you had to them:  

_______________________________________________________  
_______________________________________________________  
_______________________________________________________  
_______________________________________________________  

Last chest X-ray:__________________
Medications

What medications do you currently take:

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Occupation (please list by dates):

_________________________________
_________________________________
_________________________________

Please list the places where you have lived

_________________________________
_________________________________

Pulmonary

1. What is the main problem you are being tested for? ________________________________

2. Do you use oxygen?  ___Yes  ___No
   How much?_____________ Date started?_____________

3. Do you smoke?   ___Yes  ___No
   __Cigarettes  __Pipe  __Cigars
   If no, have you ever smoked?_______ How many cigarettes per day?_____________
   How old when you began?_________ When did you stop smoking?_________________

   ___Yes  ___No  Do you have chest pain?
   ___Yes  ___No  Do you wheeze?
   ___Yes  ___No  Do you cough?
   ___Yes  ___No  Do you cough up phlegm?  For how many years?___________
   ___Yes  ___No  Do you have shortness of breath?
   ___Yes  ___No  Have you coughed up blood in the past year?
   ___Yes  ___No  Have you ever had pneumonia?  When?
   ___Yes  ___No  Have you ever had special tests or operations performed on your lungs, chest or heart?
   ___Yes  ___No  Do you have allergies or sinus problems?
   ___Yes  ___No  Have you ever applied for, or are you receiving disability for lung or heart disease?
   ___Yes  ___No  Do you use petroleum jelly products in your nose – like Vicks or Mentholatum?
   ___Yes  ___No  Do you have heartburn or symptoms of stomach acid reflux?
   ___Yes  ___No  Do you snore?
   ___Yes  ___No  Have you ever had blood clots in your legs or lungs?
   ___Yes  ___No  Do you have swelling of feet or ankles?

What is your normal weight?________lbs.  What is your normal height?_____________

About how far can you walk on a level surface (street, path)?_______________