ENTAA Care
A member of Johns Hopkins Regional Physicians

SLEEP APNEA AND SNORING

PATIENT: _____ DATE: _____/_____/_____

	YES	NO
1. Do you snore?	❑	❑
2. How long has snoring been a problem? _____		
3. Do you feel well rested when you wake up?	❑	❑
4. Are you tired during the day?	❑	❑
5. Do you often fall asleep during the day, at work or while driving?	❑	❑
6. Do you drink alcohol?	❑	❑
7. Medications currently taking:		
_____ _____		
_____ _____		
_____ _____		
8. Do you have any of the following medical problems?		
Heart disease	❑	❑
High blood pressure	❑	❑
Lung disease	❑	❑
Stroke	❑	❑
9. Are you overweight?	❑	❑
10. Have you had a recent weight gain?	❑	❑
11. Can you breathe easily through your nose?	❑	❑
12. Have you ever broken your nose or required surgery on your nose or tonsils?	❑	❑
13. Have you had any problems with depression or lack of motivation?	❑	❑
14. Has your snoring or fatigue led to problems in your work or marriage?	❑	❑
15. Have you developed sexual problems or bed-wetting?	❑	❑
16. Have you ever been observed to stop breathing during your sleep?		
17. Other:		
Comments: _____		
_____		
_____		