Concord Otolaryngology
Head & Neck Surgery P.A.

Mark A. Carwell, MD
Christopher H. Daniell, MD
Ashok N. Reddy, MD
Brian Lee, DO
Nicole Bettencourt, AuD
A. Eliza Evans, MS, FAAA
Dwight Valdez, MA, FAAA
Libby Young, MS, FAAA

194 Pleasant Street, Suite 2, Concord, NH 03301 (603) 224-2353 Fax (603) 226-0727 www.concordoto.com

Today's Date:_____

Patient Name:_____ Date of Birth:_____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these activities recently, try to work out how they would have affected you if you did. Use the scale below to choose the most appropriate number 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 TV	_____
Sitting inactive in a public place (ie: movie theater or at a 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 without alcohol.	_____
In a car, while stopped for a few minutes in traffic.	_____
TOTAL SCORE	_____

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Sleep / Snore Questionnaire

Patient Name:_____ Today's Date:_____

Date of Birth:_____ Age:_____ Weight:_____ Height: _____

Male ❑ Female❑ Neck/ Collar Size:_____ inches.

On a scale of 1-10, please rank the loudness of your snoring (Circle one)

1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

How long have you been a snorer?_____

Has your snoring ever awakened you? ❑ Yes ❑ No

Has your bed partner noted any periods where you stop breathing? ❑ Yes ❑ No

Has snoring affected your relationship with your bed partner? ❑ Yes ❑ No

Have you ever fallen asleep while driving? ❑ Yes ❑ No

Have you ever fallen asleep while at work? ❑ Yes ❑ No

Do you ever have restless or disturbed sleep? ❑ Yes ❑ No

Do you have morning headaches? ❑ Yes ❑ No

Do you have nasal allergies? ❑ Yes ❑ No

Do you have difficulty breathing through your nose? ❑ Yes ❑ No

If yes is it intermittent? ❑ Yes ❑ No ❑ Left Side? ❑ Right Side?

Do you ever wake up gasping for air? ❑ Never ❑ Occasionally ❑Often

Do you feel tired during the day? ❑ Occasionally ❑ Often

Severity? ❑ Mild ❑ Moderate ❑ Severe

Have you had a recent, significant weight gain? ❑ Yes ❑ No

If yes please note gain of _____lbs over the past _____ months.

Your weight on your ❑ high school graduation or ❑ wedding date? _____lbs

Please list any significant medical illnesses (ie: high blood pressure, asthma, etc?)

_____

_____