# SLEEP APNEA RE-EVALUATION QUESTIONNAIRE

Date ____ /____ / ____

Name _____ Age _____

Referring doctor _____

1. Do you feel sleepy during the day? Yes____ No____ Not sure____
   Do you get sleepy driving a car on a long trip? Yes____ No ____
   Have you almost fallen asleep & had to jerk the car back on the road? Yes_____ No ____
   Ever had a car accident due to falling asleep at the wheel? Yes_____ No____
2. Have you ever fallen asleep during any of the following:
   Watching TV_____ Sitting on a couch/recliner_____ Reading a book/magazine ____
   Working at your desk/computer_____ Talking on the phone_____
3. Do you feel excessively tired or fatigued during the day?____ during the afternoon?____
4. Do other people say that you snore loudly? Yes____ No ____
   How long have you been snoring? ____ years
   Does your spouse sleep in a different room because of your snoring? Yes____ No ____
   Do other people say that you stop breathing while you sleep? Yes____ No ____
   Do other people say that you snort or gasp for breath when you sleep? Yes____ No ____
5. Do you have sudden attacks of weakness when you are laughing hard? Yes____ No ____
   Do you have vivid dreams/hallucinations just as you are falling asleep? Yes____ No ____
   Do you ever feel totally paralyzed while you are laying in bed? Yes____ No ____
   Do you have restless legs at night or jerk your legs a lot when asleep? Yes_____ No ____
6. Do you feel well-rested when you wake up from sleeping? Yes____ No ____
   Do you feel that you get a good night's sleep? Yes____ No ____
   Do you have insomnia (trouble falling asleep)? Yes____ No ____
   How long does it take you to fall asleep? ____ minutes ____ hours
   Do you wake up frequently during the night and can't fall back to sleep? Yes____ No ____
   How many hours a night do you sleep?____ From when to when? _____ to _____
   How many cups of caffeine products (coffee, tea, coke, etc.) do you drink a day?_____
   How much weight (in pounds) have you gained in the last year?____ since age 20? _____
7. Do you have any of the following:
   Morning headache_____ Poor (worsening) memory_____ Poor concentration_____
   Increased irritability (more grouchy)_____ Impotence or loss of sexual drive_____
   Post-nasal drainage (allergies)_____ Sinus congestion_____
8. List your drug allergies:_____
9. Have you ever had any of the following: Thyroid problems/thyroid tests_____
   A sleep study_____ Tonsillectomy_____ Nose, sinus, or throat surgery_____
   Tracheostomy_____ Gastric surgery (stomach bypass or stomach stapling)_____
   Other surgery_____ _____
10. Have you ever smoked cigarettes? Yes_____ No_____
    How much did you smoke?_____ How many years?_____
    If you have quit, how many years ago did you quit?_____ years ago
11. Do you drink alcohol? Yes____ No____
    What do you drink? Beer_____ Wine_____ Liquor_____
    How many drinks a day?_____ a week?_____ a month?_____
12. Are you married? Yes____ No____ What is your occupation?_____
    Have you ever had to work the night shift on a regular basis? Yes _____ No _____
13. Do any relatives (father, brothers, uncles, etc.) have sleep apnea? Yes _____ No _____
    Father's health_____ Died of_____
    Mother's health_____ Died of_____