Patient Questionnaire

CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT

Please number your complaints in the order of seriousness

- ☐ CPAP intolerance
- ☐ Difficulty falling asleep
- ☐ Fatigue
- ☐ Frequent heavy snoring
- ☐ Frequent heavy snoring which affects the sleep of others
- ☐ Insomnia
- ☐ Gasping when waking up
- ☐ Nighttime choking spells
- ☐ Significant daytime drowsiness
- ☐ Sleepiness while driving
- ☐ Witnessed apneic events
- ☐ Morning Headache
- ☐ Leg movements/Restless legs
- ☐ Teeth Grinding
- ☐ Limited Mouth Opening

Other: Write in

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

Never chance of dozing	**Slight** chance of dozing	**Moderate** chance of dozing	**High** chance of dozing	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	Sitting inactive in public place (e.g. a theatre or 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

Never = 0
Slight = 1
Moderate = 2
High = 3

Total Score: ☐

0-9: Normal
10 or more: Patient should consider seeking medical attention