

The New England Snore Center

North Shore Ear, Nose & Throat Associates, P.C.

104 Endicott Street, Suite 100, Danvers, MA 01923 • Phone: 978.745.6601 • www.nsent.com

To assist in your care and diagnosis, fill out this form and bring it with you to your appointment.
Please read each item carefully and answer all the questions.

General Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ e-mail: _____

Phone: Home: _____ Work: _____ Cell: _____

Age: _____ Date of Birth: _____ Country of Birth _____

Sex: ___M___ F Marital Status: ___ Single ___ Married Social Security # _____

Languages spoken fluently: (other than English) _____

Occupation: _____ Primary Care Physician: _____

Medical Insurance: _____ ID # _____

Insurance Subscribers Name: _____

How did you hear about the New England Snore Center?

___ Referred by physician (please specify) _____

___ Referred by friend or colleague (please specify) _____

___ Internet

___ Other (please specify) _____

Are you a vocal performer? ___ Yes ___ No (if yes, what type?) _____

Are you a wind instrument player? ___ Yes ___ No

Which areas are your main concern?

___ snoring ___ disturbed sleep ___ sleep apnea ___ other (please specify) _____

Tell us about your snoring problem

1. In your own words, please describe the nature and severity of your snoring problem.

2. How long have you had this problem? _____

3. Do you snore every night? ___ Yes ___ No

4. In which sleeping positions do you snore? Please check all that apply.

___ on your back ___ on your side ___ on your stomach

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Patient Name: _____

5. How would you rate the overall loudness of your snoring? Please rate on a scale of 0 - 5
 0 (inaudible) 1 2 3 4 5 (very loud)
6. How much does your snoring disturb others who share your bedroom? Please rate on a scale of 1 - 5
 0 (not bothersome) 1 2 3 4 5 (extremely bothersome)
7. Have you ever been evicted from your bedroom because of your snoring? Yes No
8. Have you ever been told that you stop breathing during the night? Yes No
9. Do you fall asleep easily during the day? Yes No
10. Have you ever been diagnosed with sleep apnea? Yes No
11. Have you ever undergone a sleep study? Yes No
 If yes, where? _____ When? _____

The Epworth Sleepiness Scale (ESS)

The ESS is a questionnaire designed to evaluate levels of excessive sleepiness. This test is a standardized screening tool used extensively by the American Association of Sleep Medicine (AASM) that will help you measure your general level of sleepiness. It asks you to rate the chances that you would doze off or fall asleep during different routine situations. Answers to the questions are based on a scale from 0-3, with 0 meaning you would never doze off or fall asleep in a given situation, and 3 meaning there is a very high likelihood you would doze or fall asleep in that situation.

0= would never doze 1= slight chance of dozing 2= moderate chance of dozing 3= high chance of dozing

Situation	Chance of dozing (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place, such as a theater or meeting	
As a passenger in a car for an hour without a break	
Sitting down to rest in the afternoon	
Sitting quietly after lunch (when you've had no alcohol)	
Sitting and talking to someone	
In a car, stopped in traffic	
Total Score	

The Epworth Sleepiness Scale Key

Total score of 10 or more suggests the you may need further evaluation by a physician to determine the cause of your excessive sleepiness and whether you have an underlying sleep disorder. A total score of 10 or less suggests that you may not be suffering from excessive sleepiness.

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Patient Name: _____

Medical History

1. Do you have any of the following medical conditions?

Table with 4 columns: Medical Condition, Yes, No, Comments. Rows include: Nose/Sinus Problems, Throat/Voice Problems, Heart Disease, Heart Murmur, Thyroid Condition, Speech/Articulation Problems, High Blood pressure, Stroke, Pulmonary/ Respiratory Problems, Diabetes, endocrine, or hormonal problems, Neurologic (seizures, muscle weaknesses), Cancer (If yes, specify type in comments), Temporomandibular (jaw) joint problems, Allergies/Hay Fever, Medication allergies (please list), Current Medications:

2. Do you smoke cigarettes? ___ Yes ___ No
If yes, How many packs per day? _____ How many years? _____

3. Do you drink more than one alcoholic beverage daily? ___ Yes ___ No
If yes, How many per day? ___ Per week?___
Do you drink alcohol before bedtime? ___ Yes ___ No

4. Do you take any medications to help you sleep? ___ Yes ___ No
If yes, please list medications:_____