UCLA Health

MRN:
Patient Name:

(Patient Label)

SLEEP SURGERY NEW PATIENT FORM

What specifically is the reason for your visit today? _____

Height _____ Weight _____ Neck size (collar size) _____

What was your weight 1 year ago? _____ 2 years ago? _____ At age 18? _____

Do you snore? ☐ No ☐ Yes How often? _____ (days/week) For how many years? _____

How bothersome is your snoring currently (0 = None, 10 = Severe)?

None		Mild		Moderate		Severe		Very Severe		Worst Imaginable
0	1	2	3	4	5	6	7	8	9	10

Has it worsened recently? ☐ No ☐ Yes Over how long a period of time? _____

Do you hold your breath or gasp for air while asleep? ☐ No ☐ Yes

What makes your snoring or breathing at night better or worse (sleeping on back vs. side or stomach, alcohol intake, nasal blockage, being tired)? _____

Weekday bedtime _____ wake up time: _____Weekend bedtime: _____ wake up time: _____

Do you nap? ☐ No ☐ Yes How often, and for how long? _____

How long does it take you to fall asleep at night? _____ _____

How many times do you wake up at night? _____ How long to fall back asleep? _____

In what position do you sleep ☐ back ☐ right ☐ left ☐ stomach

Feel refreshed when you wake up in the morning? ☐ No ☐ Yes

Do you frequently awaken with (check all that apply):

☐ dry mouth ☐ nasal blockage ☐ headaches ☐ excessive sweating ☐ choking or gasping

☐ chest pain ☐ heartburn or sour taste

Does fatigue limit your daily activities? ☐ No ☐ Mild ☐ Moderate ☐ Severe

Caffeinated beverages per day: coffee_____ tea _____ soda _____

Do you feel a restless sensation in your legs while lying awake in bed? ☐ No ☐ Yes

Do you make kicking or twitching movements while asleep? ☐ No ☐ Yes

Do you ever awaken feeling paralyzed? ☐ No ☐ Yes

Experience sudden loss of strength in your arms or legs during the day? ☐ No ☐ Yes

If yes, is this brought on by sudden fright or laughter? ☐ No ☐ Yes

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SLEEP SURGERY NEW PATIENT FORM

What led you to obtain a sleep study, if you have had one? _____

Have you used positive airway pressure therapy (CPAP, BiPAP, or AutoPAP)? ☐ No ☐ Yes

Describe your experience with CPAP/BiPAP/AutoPAP, including the reasons for not wearing it if you are not able to? _____

On average, how many nights a week are or were you able to wear it? _____

For how many hours per night (range and average)? _____

Still using CPAP/BiPAP/AutoPAP? ☐ No ☐ Yes Still own equipment? ☐ No ☐ Yes

If not using CPAP/BiPAP/AutoPAP, how long has it been? _____

What type of masks do you use or have you used (check all that apply)?

☐ Nasal mask (over nose) ☐ Nasal pillows (inside nostrils) ☐ Full face (over nose and mouth)

Have you ever used an oral appliance to treat sleep apnea? ☐ No ☐ Yes

If yes, what is/was your experience? _____

_____

Do you have trouble swallowing (0 = None, 10 = Severe)? _____

NASAL BREATHING

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

Is this a problem during the day? ☐ No ☐ Yes During the night? ☐ No ☐ Yes

Is your nose blocked on one side, both sides, or does it alternate between sides?

_____

Does your nasal blockage change with the time of year (seasons)? ☐ No ☐ Yes

Do you have symptoms of allergies, such as itchy or watery eyes or hay fever? ☐ No ☐ Yes

What medications or devices have you tried to treat nasal obstruction, and what has been the result?_____

_____

Patient or Representative Signature		Date	Time

If not signed by patient, indicate relationship or guardian: _____

Interpreter Signature	Interpreter ID #	Date	Time

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EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale (ESS) is a standardized a self-administered 8-item questionnaire commonly used to assess sleepiness.

Patients are given the following instructions:

The questionnaire asks you to rate the chances that you would doze off or fall asleep during different routine situations. Answers to the questions are rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high likelihood that you would doze or fall asleep in that situation.

Use the following scale 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**			
	Never (0)	**Slight (1)**	**Mod (2)**	**High (3)**
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive, in a public place *(e.g. a theater or 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	☐	☐	☐	☐

Patient or Representative Signature _____

Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ ID # _____

Date _____ Time _____

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FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE (FOSQ)

Please mark "✓" as appropriate	1 Yes, extreme	2 Yes, Moderate	3 Yes, a little	4 No
1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?	☐	☐	☐	☐
2. Do you generally have difficulty remembering things, because you are sleepy or tired?	☐	☐	☐	☐
3. Do you have difficulty finishing a meal because you become sleepy or tired?	☐	☐	☐	☐
4. Do you have difficulty working on a hobby (for example, sewing, collecting, gardening) because you are sleepy or tired?	☐	☐	☐	☐
5. Do you have difficulty doing work around the house (for example, cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired?	☐	☐	☐	☐
6. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐
7. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐
8. Do you have difficulty getting things done because you are too sleepy or tired to drive or take public transportation?	☐	☐	☐	☐
9. Do you have difficulty taking care of financial affairs and doing paperwork (for example, writing checks, paying bills, keeping financial records, filling out tax forms, etc.) because you are sleepy or tired?	☐	☐	☐	☐
10. Do you have difficulty performing employed or volunteer work because you are sleepy or tired?	☐	☐	☐	☐
	FOSQ-10 Score		_____	

_____ _____ _____

Patient or Representative Signature | Date | Time

If not signed by patient, indicate relationship or guardian: _____

_____ _____ _____ _____

Interpreter Signature | Interpreter ID # | Date | Time

Source : Weaver (1996) Functional Outcomes of Sleep Questionnaire (FOSQ)

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INSOMNIA SEVERITY INDEX
Patient Questionnaire

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very
1. Difficulty falling asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. Difficulty staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. Problems waking up too early	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all noticeable	A little	Somewhat	Much	Very much noticeable
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all worried	A little	Somewhat	Much	Very much worried
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all interfering	A little	Somewhat	Much	Very much interfering
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

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INSOMNIA SEVERITY INDEX
Patient Questionnaire

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If not signed by patient, indicate relationship or guardian: _____

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Guidelines for Scoring/Interpretation:

Add the scores for all seven items:

(Questions 1 + 2 + 3 + 4 + 5 +6 + 7) =_____your total score

Total score categories:

0–7	= No clinically significant insomnia
8–14	= Subthreshold insomnia
15–21	= Clinical insomnia (moderate severity)
22–28	= Clinical insomnia (severe)

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NASAL OBSTRUCTION SYMPTOM EVALUATION (NOSE) INSTRUMENT

Patient Questionnaire

Please help us to better understand the impact of nasal obstruction on your quality of life by completing the following survey.

Over the past 1 month, how much of a problem were the following conditions for you?

	Please check the most correct response				
	Not a problem	Very mild problem	Moderate problem	Fairly bad problem	Severe problem
1. Nasal congestion or stuffiness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. Nasal blockage or obstruction	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. Trouble breathing through my nose	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. Trouble sleeping	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. Unable to get enough air through my nose during exercise or exertion	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Patient or Representative Signature _____ Date _____ Time _____

If not signed by patient, indicate relationship or guardian: _____

Interpreter Signature _____ Interpreter ID # _____ Date _____ Time _____

The Nasal Obstruction Symptom Evaluation (NOSE) scale. Reprinted from reference 3 with permission from John Wiley and sons.