UCLA Health

MRN:
Patient Name:

(Patient Label)

SLEEP SURGERY POSTOPERATIVE FORM

Height _____ Weight _____ Weight prior to surgery: _____

Do you snore? ☐ No ☐ Yes How often? _____ (days/week)

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

How has your snoring changed since surgery? ☐ No ☐ Yes

Weekday bedtime _____ and wake up time: _____Weekend: _____

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? _____

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

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

How have your sleep quality and fatigue changed since surgery? _____

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

In terms of your sleep apnea and your health, has there been any change in your quality of life (without any other treatment like CPAP) since the first time you came to see our sleep surgery team?

Better (choose option below) ☐ About the Same Worse, choose option below

☐ Hardly better at all
☐ A little better
☐ Somewhat better
☐ Moderately better
☐ A good deal better
☐ A great deal better
☐ A very great deal better

☐ Hardly worse at all
☐ A little worse
☐ Somewhat worse
☐ Moderately worse
☐ A good deal worse
☐ A great deal worse
☐ A very great deal worse

_____ _____ _____

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

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_____ _____ _____ _____

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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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.