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Nose and Sinus Clinic

Questionnaire for LAUP Candidates

NAME: ____ DATE:
SEX: _____ AGE: _____ DOB: ______________ HEIGHT: _______ WEIGHT:

I. MEDICAL HISTORY (Please fill in the appropriate areas)
Medication Allergies: ________________________________
Current Medications: ____

II. GENERAL HEALTH HISTORY
1. Do you smoke? YES NO Quantity per day: _____ X _____ Years
2. Have you ever smoked? YES NO If yes, when did you stop? ___
3. Are you exposed to cigarette smoke? YES NO
If so, where? Home _____ Work _____
4. Do you drink alcohol? YES NO Quantity per day (Approx.): ____________
5. Do you exercise? YES NO If so, what type of activity (Specify):
- ____
6. Have you recently had a change in weight? YES NO If yes, over what period of time (Specify)? _____ Years _____ Months How many pounds? __________ lbs
7. Have you been on a diet to lose weight? YES NO

III. PAST MEDICAL ILLNESSES (Requiring medication or hospitalization)
1. High Blood Pressure.. YES NO
2. Irregular Heart Beat.. YES NO
3. Heart Failure .... YES NO
4. Heart Valve Replacement.. YES NO
5. Stroke .... YES NO
6. Cancer .... YES NO
Specify: ____
7. Pulmonary/Respiratory.. YES NO
Specify: ____
8. Chronic Sinusitis .... YES NO
9. Nasal Fracture or Nasal Trauma.. YES NO
10. Hay fever/Allergies.. YES NO
Treatment? ____
11. Sleep Apnea .... YES NO
C-Pap Treatment? _______________________________________
12. Diabetes/Hypoglycemia.. YES NO
13. Thyroid Disease.. YES NO

14. Neurologic .... YES NO
15. Emotional .... YES NO

IV. PAST SURGICAL HISTORY (Please write the approximate date you had the surgery/surgeries)

1. Nasal Surgery .... ____________
2. Sinus Surgery .... ____________
3. Tonsillectomy .... ____________
4. Adenoidectomy....................................... ____________
5. Tracheotomy .... ____________
6. Uvulopalatoplasty (UPPP)....................... ____________
7. Other Surgery (Specify)........................... ____________

V. SYMPTOMS (Circle any which you have experienced in the recent past)

1. Snore loudly
2. Snore most every night
3. Choke, struggle for breath
4. Wake up gasping for breath
5. Awaken repeatedly because of breathing problem
   5a. Daytime? YES NO
6. Nasal obstruction
   6a. Bedtime? YES NO
7. Stop breathing during sleep
8. Restless, disturbed sleep
9. Toss and turn frequently during sleep
10. Kick or jerk legs repeatedly during sleep
11. Partner sleeps in another room due to snoring
12. Headaches upon awakening
13. Tired all of the time
14. Falling asleep during the day or after meals
15. Become drowsy while driving an automobile
16. Trouble concentrating or memory problems
17. Dry mouth or sore throat upon awakening
18. Difficulty swallowing

VI. BACKGROUND INFORMATION IN REGARDS TO SNORING

1. In your own words, describe precisely the nature and severity of your problem:
   ____
2. How long have you had this problem?
3. Did your problem start (Circle): Suddenly Gradually Intermittently
   Other (Specify): ____
4. Does your roommate/spouse (Circle all that apply):
   a. Complain b. Complain bitterly c. Wake you up d. Sleep in another room
5. Estimate the number of rooms away people can hear you snore (Circle):
   1 2 3 4 Downstairs

VII. PREVIOUS TREATMENT

1. Have you ever been treated for snoring? YES NO If yes, specify type of treatment:

IF NO, PLEASE SKIP TO QUESTION #2

On a scale of 1 thru 7, please rate the following questions:
1 = Very Dissatisfied
2 = Moderately Worse
3 = Somewhat Worse
4 = No Change
5 = Somewhat Improved
6 = Moderately Improved
7 = Much Improved

A. Rate the condition of your snoring problem following snoring treatment:

B. Rate the satisfaction with the snoring treatment you have received thus far:

C. Rate the degree of your motivation to alleviate your snoring problem:

2. Have you ever been diagnosed with sleep apnea? YES NO If yes, by whom and when? ____

3. Have you ever had a sleep study? YES NO

4. Have you had previous treatment for sleep apnea? YES NO When and where?

VIII. PLEASE EXPLAIN YOUR TREATMENT GOALS (ie: What you wish to accomplish after having received medical treatment from this facility)

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