Atlanta CENTER FOR ENT & FACIAL PLASTIC SURGERY

Nasopharyngeal/Oropharyngeal Obstruction History Sheet

Do you snore? ___yes ____no

How long have you snored? _____

What is your present weight? _____

What is your present height? _____

Do you awake with a headache? ___yes ____no

If yes, how many times weekly? _____

Do you awake with a dry mouth? ___yes ____no

Do you have trouble breathing through your mouth or do you Feel like something is in your throat? ___yes ____no

Do you awake rested most of the time? ___yes ____no

If no, do you get recurrently sleepy during the day at times other than after lunch? ___yes ____no

Do you doze/nod off when you are inactive? ___yes ____no

Have you ever awakened with the feeling that you could not breathe? ___yes ____no

Have you ever been told that you stop breathing while you are asleep? ___yes ___no

Do you have shortness of breath? ___yes ___no

If yes, how many times a day? _____

OR

How many times a week? _____

Have you been diagnosed with sleep apnea? ____yes ____no

If yes, by whom and when?_____

NAME:_____**DATE:**_____