TIMOTHY H. TRONE, M.D.
DALLAS ENT GROUP

Sleep Disordered Breathing Report

Last Name:_____ First Name:_____ Date:_____

Age:_____ Sex:_____ Height:_____Weight:_____ Neck Size:_____

Chief Complaint

Snoring:_____ Sleepiness/Fatigue:_____ Other:_____

Snoring

1. Do you snore no matter what position you are lying in?	Yes	No	Do Not Know
2. Do you snore every night:	Yes	No	Do Not Know
3. Is your snoring interrupted by pauses and/or choking sounds?	Yes	No	Do Not Know
4. Has your sleep mate ever commented on your snoring?	Yes	No	Do Not Know
5. Do you "grind" your teeth at night?	Yes	No	Do Not Know
6. Do you have high blood pressure?	Yes	No	Do Not Know

7. On a scale of 1-10 with 10 being loudest, how loud is your snoring? _____
8. Other comments:_____

_____

Sleepiness/Fatigue

2. How would you describe yourself? (Check all that apply)

   Fatigued:_____ Sleepy:_____ Tired:_____ Other:_____

3. What tasks or activities have you eliminated or find difficulty in completing?

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4. What is your energy level on a scale of 1-10?

   No energy 1 2 3 4 5 6 7 8 9 10 Very high energy

5. Other comments:_____

Sleep

2. Average time you go to sleep?_____
3. Average time you wake up?_____
4. Is it difficult to fall asleep if you awake during the night to go back to sleep? Yes No
5. How often do you awake during the night (bathroom, clock, noises, etc…)?_____
6. What is the quality of your sleep? Very Poor 1 2 3 4 5 6 7 8 9 10 Excellent
7. Other comments:_____

Other Symptoms (check all that apply)

Allergies	_____	Impotence	_____	Sore throat	_____
Depression	_____	Recent weight gain	_____	Teeth grinding	_____
Headache	_____	Reflux	_____		

History

1. Have you ever been treated for your snoring or sleep disorder? Yes No Do Not Know
2. If yes, by whom?_____

Address and Phone number (if known):

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3. If yes, what was the date of the evaluation?_____
4. If yes, what was the diagnosis (if known)?_____
5. Describe any treatment that you may have received and the success and/or failure you experienced.
