OrthoApnea®

Questionnaire for **patients (1 of 2)**

Personal Information

First Name:______________________ Last Name:______________________

Date of birth:____________ Sex:__________ Weight:____________ Height:____________

Alcohol consumption (days per week):________ Former smoker________ Smoking (cigarettes per week):__________

Medical History

Respiratory problems	☐ Yes	☐ No
Cardiovascular problems	☐ Yes	☐ No
Kidney problems	☐ Yes	☐ No
Digestive problems	☐ Yes	☐ No
Neurologic problems	☐ Yes	☐ No

Please, check YES or NO **(You may need to ask your sleeping partner)**.

1. Do you usually snore?	☐ Yes	☐ No
2. Do you snore when you sleep with your mouth open?	☐ Yes	☐ No
3. Do you snore when you sleep on your side?	☐ Yes	☐ No
4. Is your snoring worse after drinking alcohol?	☐ Yes	☐ No
5. Is your snoring worse when you are ill or suffering from allergies?	☐ Yes	☐ No
6. Do you have difficulty falling asleep?	☐ Yes	☐ No
7. Do you usually take sleep aids or sleeping pills?	☐ Yes	☐ No
8. Do you feel like sufficating during the night?	☐ Yes	☐ No
9. Have you ever stopped breathing while sleeping?	☐ Yes	☐ No
10. Do you usually get up at night to pass urine?	☐ Yes	☐ No
11. Do you clench your mandible or grind your teeth during the sleep?	☐ Yes	☐ No
12. Is your sleep disturbed due to an urge to move your arms and/or legs?	☐ Yes	☐ No
13. Do you have nightmares or strange dreams during the sleep?	☐ Yes	☐ No
14. Do you feel tired when you wake up?	☐ Yes	☐ No
15. Do you usually wake up with a headache?	☐ Yes	☐ No
16. Do you feel sleepy during the day?	☐ Yes	☐ No
17. Do you have problems concentrating throughout the day?	☐ Yes	☐ No
18. Are you suffering a decline in your intellectual abilities?	☐ Yes	☐ No
19. Do you feel pain in your jaw or cheeks?	☐ Yes	☐ No
20. Do you have a toothache?	☐ Yes	☐ No
21. Have you ever injured your nose or undergone any type of nasal surgery?	☐ Yes	☐ No
22. Do you have your tonsils removed?	☐ Yes	☐ No
23. Is your nose obstructed?	☐ Yes	☐ No
24. Have you ever had a sleep study or polysomnography?	☐ Yes	☐ No
25. Have you ever received treatment for snoring and/or sleep apnea?	☐ Yes	☐ No

If yes, When? ______________________

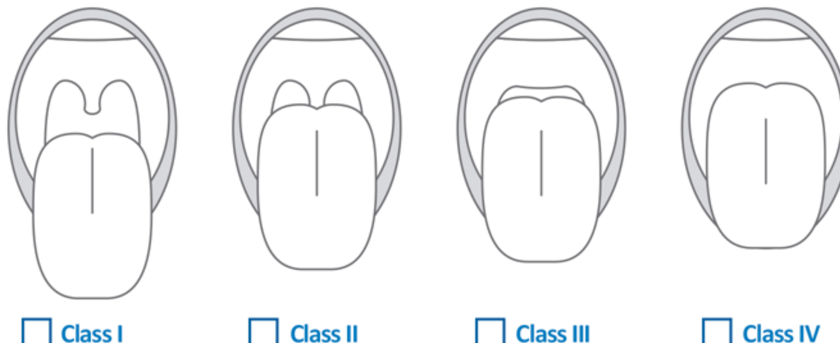
This information is totally confidential. The answers will be used to diagnose the patient's problems derived from sleeping or sleep apnea. In compliance with the provisions of LOPD Law 15/1999, you are guaranteed with complete confidentiality. The data provided will not be used in any database and will not be used for commercial purposes.

OrthoApnea

Questionnaire for **patients (2 of 2)**

The Mallampati Classification

Mark the picture that is the most similar to your oral cavity. Consult with your doctor to choose correctly the class you appear to have:



☐ Class I ☐ Class II ☐ Class III ☐ Class IV

Epworth daytime sleepiness questionnaire

This questionnaire aims to assess fatigue, sleepiness, or wanting to fall asleep in each of the following situations. Although you may not have experienced any of these situations, try to imagine how they might affect you.

Evaluate the different situations below by checking 0 - 3 according to the scale.

0= I never feel sleepy

1= I may feel somewhat sleepy

2= I would most likely feel sleepy

3= I most definitely feel sleepy

Activity	Score 0	1	2	3
Sitting and Reading	☐	☐	☐	☐
Watching the TV	☐	☐	☐	☐
Sitting inactive in a public place	☐	☐	☐	☐
Riding as the passenger in a car for an hour straight	☐	☐	☐	☐
Resting/Lying in the afternoon when the circumstances permit that	☐	☐	☐	☐
Sitting and chatting with somebody	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐
When sitting in the car and waiting for the green light	☐	☐	☐	☐
	☐	☐	☐	☐

Total Score: ____________________

If your score is less than 6, you have little to no fatigue. If your score is between 7 - 8 you suffer from fatigue, and if your score is over 9, then your fatigue is excessive.

Sign to confirm the transfer of data necessary for your study:

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