
Patient's Dozing and Snoring Grading Forms

Patients Name: _____ Date: _____

Epworth Sleepiness Scale:

Instructions: In contrast to just feeling tired, how likely is the patient to dose off or fall asleep in the following situations?

Using the following scale to choose the most appropriate number for each situation:

0-Would never dose

1-Slight Chance of Dozing

2-Moderate Chance of Dozing

3-High Chance of Dozing

Situations:

- Sitting and reading _____
- Watching Television _____
- Sitting inactive in a public place (ie. In a movie theater) _____
- As a car passenger for an hour without a break _____
- Lying down to rest in the afternoon _____
- Sitting and talking to someone _____
- Sitting quietly after lunch, without alcohol in a car,
while stopped for a few minutes in traffic _____

TOTAL SCORE: _____

A score of 8 or greater indicates the possibility of sleep disordered breathing.

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Thornton Snoring Score:

Instructions: Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around them both physically and emotionally.

Use the following score to choose the most appropriate number for each situation.

(Only answer last 2 statement is patient has no sleeping partner)

0-Never

1-infrequently (1 night/wk)

2-Frequently (2-3 Nights/wk)

3-Most of the time (4 or more nights/wk)

- Snoring affects patient's relationship with partner _____
- Patient's snoring causes their partner to be irritable/tired _____
- Patient's snoring requires partner to sleep in separate rooms _____
- Patient's snoring is loud _____
- Patient's snoring affects people when sleeping away from home
(Hotel, Camping etc.) _____

TOTAL SCORE: _____

A score of 5 or greater indicates snoring may be significantly affecting quality of life.

SNORELAB – SNORE SCORE:

Patients Sleeping Habits & Snoring Assessment
Form **Before** First NightLase Treatment for Snoring

Patients Name: _____ Date: _____

The purpose of this form is to provide information on the quality of your sleep and snoring levels. Please answer these questions as your own thoughts on your sleeping habits. If you have a sleep partner it would be beneficial to have them to complete the sleep partner's form on their perspective of your sleep habits.

Overall, how would you **rate the quality** of your sleep? (10 being highest)

10 9 8 7 6 5 4 3 2 1 0

On average **how many hours a night do you sleep?** _____ hours

How often do you snore? (Very Often=10, Occasionally=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

How would you **rate the noise level of your snoring?** (10 being highest)

10 9 8 7 6 5 4 3 2 1 0

How often **does your snoring wake you up** at night? (Very Often=10, Occasionally=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

Do you **ever gasp for breath at night?** (Very Often=10, Occasionally=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

How would you **rate your restlessness** while sleeping? (10 being very restless)

10 9 8 7 6 5 4 3 2 1 0

On average how many times **do you get up during the night?**

10 9 8 7 6 5 4 3 2 1 0

Do you **wake up with a dry mouth?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

Do you **wake up with a sore throat?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

Patients Sleeping Habits & Snoring Assessment
*Form **Before** First NightLase Treatment for Snoring*

How often do you **have morning headaches?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

Do you feel a lack of sleep or **wake up tired?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

Do you have **difficulty waking up in the morning?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

Do you **feel sleepy, tired, and/or fatigued during the day?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

Do you **fall asleep during the day at unwanted times?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

Do you have a sleep partner (spouse, significant other, etc.) that would be willing to complete a survey to evaluate your sleeping habits and snoring **from their perspectives?**

If yes, their Name (optional) : _____

*Sleep **Partner's** Assessment of the Patient's Sleep Habits
Before First NightLase Treatment for Snoring Form*

Patients Name: _____ Date: _____

The purpose of this form is to provide information on the patient's quality of sleep and their snoring levels to enable an accurate assessment of their sleeping habits.

Please answer these questions as they pertain to your observations of the patient and their sleep habits.

Overall, how would you rate the **quality** of the patient's sleep? (10 being highest)

10 9 8 7 6 5 4 3 2 1 0

On average **how many hours a night does the patient sleep?** _____ hours

How often does the patient snore? (Very Often=10, Occasionally=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

How would you rate the **noise level** of their snoring? (10 being highest)

10 9 8 7 6 5 4 3 2 1 0

How often **does their snoring wake you up** at night? (Very Often=10, Occasionally=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

Do they **ever gasp for breath at night?** (Very Often=10, Occasionally=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

How would you **rate their restlessness** while sleeping? (10 being very restless)

10 9 8 7 6 5 4 3 2 1 0

On average how many times **do they get up during the night?**

10 9 8 7 6 5 4 3 2 1 0

Do they **wake up complaining about a dry mouth?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

*Sleep **Partner's** Assessment of the Patient's Sleep Habits
Before First NightLase Treatment for Snoring Form*

Do they **wake up complaining about a sore throat?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

How often do they complain about **morning headaches?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

Do they ever complain about **waking up tired?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

Do they have **difficulty waking up in the morning?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

Do they **feel sleepy, tired, and/or fatigued during the day?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

Do they **fall asleep during the day at unwanted times?** (Always=10, Sometimes=5, Never=0)

10 9 8 7 6 5 4 3 2 1 0

How much does the **patient's snoring and restlessness bother you?** (10 being a lot)

10 9 8 7 6 5 4 3 2 1 0

Your Name (optional) : _____