

Sleep Disorder Questionnaire

Patient Name: _____ Height: _____
 Gender: **M** **F** Age: _____ Weight: _____
 Neck Size: _____

Please circle answer:

Do you snore:	None	Soft	Moderate	Loud	Disruptive
Snoring can be heard outside of the bedroom				Yes	No
Snoring is present only when sleeping on back?				Yes	No
Do you have unexplained awakenings from sleep?				Yes	No
Do you awaken from sleep gasping for air or choking?				Yes	No
Do you notice frequent twitching or jerking of legs while asleep?				Yes	No
Do you lack energy upon waking in the morning?				Yes	No
Do you have a headache upon waking in the morning?				Yes	No
Do you often lay in bed unable to fall asleep?				Yes	No
Do you find it difficult to stay awake during the day?				Yes	No

*****If you have answered YES to any one of the above questions please consult with your doctor*****

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Please answer with a 0 to 3

0 = Would never doze **1 = Slight chance of dozing**
2 = Moderate chance of dozing **3 = High chance of dozing**

Sitting and reading	_____
Watching T.V.	_____
Sitting inactive in a public place	_____
As a passenger in a car 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	_____

*****If your Epworth score is 10 or greater please consult with your doctor*****

Physician Name: _____

Phone: _____ Fax: _____

Sleep Questionnaire Provided By REM Sleep Labs (888) 866-1211