SLEEP QUESTIONNAIRE FOR ADULTS

Name_____ DOB_____ Date_____

Weight (pounds) _____ Height (feet/inches)_____ Neck Size (inches) _____

Please read each item carefully and check those that apply to you. Include more detailed information when possible.

- ❑ I regularly drink alcohol in the evening
- ❑ I have been told that I snore heavily most nights
- ❑ I have been told that I have long pauses in my breathing during sleep which can be as long as _____ seconds duration
- ❑ I awaken or fall asleep feeling paralyzed
- ❑ I have night sweats
- ❑ My legs jerk frequently or feel uncomfortable or restless before or during sleep
- ❑ I have been told that I thrash in your sleep
- ❑ I have been know to wet the bed
- ❑ I often feel tired when I get up
- ❑ Sleep loss affect my mood which can make me feel tense, irritable or depressed
- ❑ I find myself falling asleep when I don't want to, such as while watching TV, driving or sitting in a meeting
- ❑ I have excessive sleepiness or fatigue that interferes with my work and/or social life
- ❑ I have had accidents (or near accidents) due to excessive sleepiness
- ❑ I need to take naps
- ❑ I have trouble with sexual functioning
- ❑ I awaken with headaches
- ❑ I awaken with jaw pain
- ❑ I have been told that I grind your teeth during sleep
- ❑ My weight has increased by more than 15 pounds in the past year. How much? _____
- ❑ My energy level down
- ❑ I have nasal congestion and/or allergies
- ❑ My snoring affects my relationship with my sleep partner

Epworth Sleepiness Scale: This questionnaire was developed to determine the level of daytime sleepiness in individuals. It has become one of the most frequently used methods for determining a person's average level of daytime sleepiness. Please rate how likely you are to doze or fall asleep in the following situations by selecting the response that best applies. If you have not done some of these activities recently, select what would most likely happen if you were in that situation.

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

	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (eg, a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
			Total Score:	

Normal 0-10. Excessive Daytime Sleepiness >10. High Levels of Excessive Daytime Sleepiness 16.