

SLEEP QUESTIONNAIRE

Patient Name: _____

Date of Birth: _____

CURRENT THERAPIES:

Have you ever been diagnosed with sleep apnea? YES NO

Do you now or have you ever used a CPAP machine? YES NO

SLEEP OBSERVATIONS:

Do you know if you snore or have you ever been told you do? YES NO

Do you have difficulty breathing while lying on your back? YES NO

Do you ever wake up gasping for air? YES NO

Do you often feel tired or fatigued after a good nights sleep? YES NO

Has anyone ever noticed that you stop breathing during sleep? YES NO

EPWORTH SLEEP 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. Use the following scale to choose the most appropriate number for each situation. Please circle the numbers below to answer.

| | <i>Would Never doze dozing</i> | <i>Slight chance of dozing</i> | <i>Moderate chance of dozing</i> | <i>High chance of dozing</i> |
|--|--|------------------------------------|--------------------------------------|----------------------------------|
| *Sitting and reading | 0 | 1 | 2 | 3 |
| *Watching TV | 0 | 1 | 2 | 3 |
| *Sitting inactive in a public place | 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 | 0 | 1 | 2 | 3 |

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| *Sitting and talking to someone | 0 | 1 | 2 | 3 |
| *Sitting quietly after lunch without alcohol 3 | 0 | 1 | 2 | |
| *In a car while stopped for a few minutes in traffic 3 | 0 | 1 | 2 | |

TOTAL OF YOUR SCORE: _____