Sleep Questionnaire

Name:_____ Date:_____

Y N Do You Snore?
Y N Have you been told you stop breathing or gasp for air when sleeping?
Y N Have you ever awakened with your heart racing?
Y N Do you wake up often throughout the night?
Y N Do you wake up with headaches?
Y N Do you sweat at night?
Y N Do you wake up more than once to urinate?
Y N Do you wake up tired or often feel tired throughout the day?
Y N Have you recently gained weight or have difficulty losing weight?
Y N Do you suffer from acid reflux?
Y N Do you have high blood pressure or take medication for high blood pressure?
Y N Do you have heart disease?
Y N Do you have diabetes?
Y N Are you short tempered or get irritated easily?
Y N Do you smoke?

EPWORTH SLEEPINESS SCALE

Use the following scale to choose the most appropriate answer for each situation?

0= would never fall asleep

1= Slight chance of falling asleep
2= Moderate chance of falling asleep
3= High chance of falling asleep

Situation Chance of dozing

Sitting and reading..... ☐

Watching TV..... ☐

Sitting, inactive in a public place (e.g. a theatre or a meeting) ..... ☐

As a passenger in a car for an hour without a break ..... ☐

Lying down to rest in the afternoon when circumstances permit ..... ☐

Sitting and talking to someone ..... ☐

Sitting quietly after a lunch without alcohol ..... ☐

In a car, while stopped for a few minutes in the traffic ..... ☐

Total..... ☐