ENT SURGICAL CONSULTANTS

SLEEP QUESTIONNAIRE FOR ADULTS (12/05)

Name____Date_______________________

Please read each item carefully and check those that apply to you. It would be helpful to include more detailed information when possible.

Weight ___________lbs Height_______________ Neck Size___________inches

- ❑ Do you regularly drink alcohol in the evening?
- ❑ Have you been told that you snore heavily most nights?
- ❑ Have you been told you have long pauses in your breathing during sleep? How many seconds? _____
- ❑ Do you awaken or fall asleep feeling paralyzed?
- ❑ Do you have night sweats?
- ❑ Do you legs jerk frequently or feel uncomfortable or restless before or during sleep?
- ❑ Do you thrash in your sleep?
- ❑ Do you wet the bed?
- ❑ Do you often feel tired when you get up?
- ❑ Does sleep loss affect your mood? Do you feel tense, irritable or depressed?
- ❑ Do you find yourself falling asleep when you don't want to, such as while watching TV, driving or sitting in a meeting?
- ❑ Does excessive sleepiness/fatigue interfere with your work or social life?
- ❑ Have you had any accidents (or near accidents) because of excessive sleepiness?
- ❑ Do you have to take naps?
- ❑ Do you have trouble with sexual functioning?
- ❑ Do you awaken with a headache?
- ❑ Do you awaken with jaw pain?
- ❑ Have you been told that you grind your teeth during sleep?
- ❑ Has your weight increased by more than 15 pounds in the past year? How much? _________
- ❑ Is your energy level down?
- ❑ Do you have nasal allergies?
- ❑ Has snoring affected your relationship with your sleep partner?