

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?