

Sleep Disorder Screening Questionnaire

Height		Weight		Name		Age	
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What time do you usually go to bed? _____ AM/PM Do you have difficulty getting to sleep? Yes No

What time do you usually wake up? _____ AM/PM Do you feel rested when waking up? Yes No

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 the past few months. Even if you have not done some of these things recently, try to work out how they would have affected you. Choose the most appropriate number for each situation.

0 = Would never fall asleep 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

Situation	Chance of Dozing
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting in a public place (i.e., 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
Epworth Sleepiness Scale Total=	

- Have you been told or suspect that you snore while sleeping? Yes No
- Have you been told or suspect that you stop breathing while sleeping? Yes No
- Have you been told or suspect that you talk or behave irregularly during sleep? Yes No
- Have you ever been told or suspect that you kick, hit, or twitch while sleeping? Yes No
- During sleep, do you wake frequently due to pain, noise, or other reasons? Yes No
- During your day, do you often feel tired or fatigued and have difficulty staying awake? Yes No
- Have you recently found yourself nodding off or sleeping while driving a vehicle? Yes No
- During periods of strong emotion, do you tend to collapse or feel extreme fatigue? Yes No
- During your day, do you experience the urge to tap or move your legs/feet? Yes No
- Do you have High Blood Pressure or other Heart related problems? Yes No

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