SLEEP DISORDERS QUESTIONNAIRE

Thank you for your cooperation in filling out this brief questionnaire.

Name: ____________________________________________ Date: __________________

Age: ________ Sex: ________ Height: ________ Weight: ________________

1. How many hours do you usually sleep during a weekday night prior to work? ____________
   
   Please fill out the following schedule for weekdays only:
   
   To bed time: __________ Fall asleep time: __________ Wake up time: __________

2. How many, if any, awakenings do you have at night? ____________

3. Are you a restless sleeper who tosses and turns or kicks off the covers at night?  
   Yes       No

4. Do you snore?  
   Yes       No
   
   If yes, indicate the severity by circling one number:
   Mild -  1  2  3  4  5 - Heavy

5. Do you snore if you sleep while lying on your side?  
   Yes       No

6. Has anyone indicated that your breaths during sleep are interrupted or irregular?  
   Yes       No
   
   If yes, have these instances become more frequent per night since first noticed?  
   Yes       No

7. Please list any known medical problems:
   __________________________________________________________________________
   __________________________________________________________________________

   Do you have a history of irregular heart beats or previous heart attack?  
   Yes       No

   Do you have high blood pressure?  
   Yes       No

   Do you have any previous thyroid problem?  
   Yes       No
   
   If yes, please explain: ______________________________________________________

8. Do you take any sedatives, sleeping medications, or alcohol in the evening to help you fall 
   asleep?  
   Yes       No
   
   If yes, please explain: _____________________________________________________

   __________________________________________________________________________
9. 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. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

- 0 - would never doze
- 1 - slight chance of dozing
- 2 - moderate chance of dozing
- 3 - high chance of dozing

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>CHANCE OF DOZING</th>
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<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
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<tr>
<td>Watching TV</td>
<td></td>
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<tr>
<td>Sitting, inactive, in a public place (e.g. theater or a meeting)</td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
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<tr>
<td>Lying down to rest in the afternoon</td>
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<tr>
<td>Sitting quietly after a lunch without alcohol</td>
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<tr>
<td>In a car, while stopped for a few minutes in the traffic</td>
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</tbody>
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THANK YOU FOR YOUR COOPERATION

Jointly prepared with THE NATIONAL SLEEP CENTER for use as a screening device for potential sleep disorders.

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