

Pre-study Questionnaire

Patient Name: _____ Date: _____

Date of Birth: _____ Your Height: _____ Your Weight: _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?	Chance of Dozing Off			
	Never	Slight	Moderate	High
Sitting and reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting quietly in a public place (theater or a meeting)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As a passenger in a car for an hour without eating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down to rest in the afternoon	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting while talking with someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting quietly after lunch without alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In a car, while stopped for a few minutes in traffic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please check one box per line

Brief Sleep Symptom Checklist

Never	Rarely	Often	Always	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I snore loudly
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I wake gasping or choking for breath
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I awaken in the morning unrefreshed
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I have problems falling asleep or staying asleep (insomnia)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	My sleep is very restless
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	My sleep is disturbed by unusual behaviors (ex: nightmares, sleepwalking, dream enactments, tongue biting, bed-wetting)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fall asleep while driving
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I've been told that I stop breathing in my sleep (told by _____)

Please check the boxes that best describe you

Sleep Schedule

Please provide the following information

What time do you go to bed on **weekdays**? _____ AM or PM Do you take naps? Yes No

What time do you get up on **weekdays**? _____ AM or PM If yes, how often do you nap? _____ times per week

What time do you go to bed on **weekends**? _____ AM or PM How long are the naps? _____ minutes

What time do you get up on **weekends**? _____ AM or PM Do you awaken refreshed? Yes No

Are you a shift worker? Yes No If yes, what kind of shift do you work? _____

