SLEEP QUESTIONAIRE

Name: ____ DOB: ______________ Date: ______________

Please check yes to those that apply

	No	Yes
Are you sleepy, tired, or exhausted during the day?		
Have you been told that you snore, or your breathing is interrupted while you sleep?		
Do you have a weight problem?		
Do you awaken in the morning without feeling refreshed?		
Have you been diagnosed with hypertension, diabetes, or depression?		
Do you awaken at night or in the morning with headaches?		
Do your legs jerks frequently or feel uncomfortable or restless before during sleep?		
Have you experienced memory loss?		
Does your heart beating irregularly race at night?		
Do you ever experience “sleep paralysis” before falling asleep or after awakening?		
Do you experience hallucinations before falling asleep after awakening?		
Are you suffering from sexual dysfunction?		

THE EPWORTH SLEEPINESS SCALE (ESS)

Check the appropriate boxes to indicate the chance of dozing or feeling very sleepy

Situation	**Chance of Dozing**			
	Never (0)	Slight (1)	Moderate (2)	High (3)
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (i.e., movie theater)				
Sitting and talking to someone after lunch				
As a passenger for an hour without a break				
In a car, while stopped for a few minutes in traffic				
Driving a vehicle for two or more hours				
Lying down to rest in the afternoon when possible				

Total Score: _______

A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy.
Score of ESS is 10 or more suggests a sleep disorder, and a sleep study is warranted.