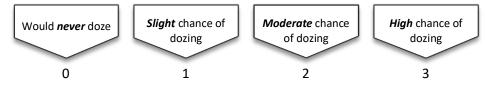
Intake Sleep Questionnaire

Name:	_DOB:	Date:	
	1. Neck circumfere	xam (completed by nurse) rcumference (Normal < 40cm):_ ass index (Normal < 35 Kg/m ²):	
1. Do you snore excessively?	Yes	No	
2. Do you awaken tired in the morning?	Yes		
3. Do you awaken gasping for air?	Yes		
4. Do you awaken with dry mouth?	Yes	No	
5. Do you awaken with headaches?	Yes	No	
6. Do you move frequently during the night?	Yes		
7. Do you have high blood pressure?	Yes		
8. Do you have difficulty concentrating?	Yes		
9. Are you over your ideal weight?	Yes	No	
10. Do you have coronary artery disease?	Yes	No	
11. Do you have congestive heart failure?	Yes	No	
12. Have you had a stroke?	Yes		
13. Has anyone witnessed apnea spells during you	r sleep? Yes		
14. Are you excessively tired during the day? *If "y question 14, answer the following questions*			
Total: (Add each	column)		

Total. (Add each column)



	Chance of Dozing			
1. Sitting and reading	0	1	2	3
2. Watching television	0	1	2	3
3. Sitting inactive in a public place (e.g., a theater or a meeting)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon when circumstances permit	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after a lunch without alcohol	0	1	2	3
8. In a car, while stopped for a few minutes in traffic	0	1	2	3

Total Score: (Add column 1-8)

