Intake Sleep Questionnaire

Name:_____ **DOB:**_____ **Date:**_____

Duration of symptoms_____

Physical Exam (completed by nurse)

1. **Neck circumference (Normal < 40cm):**_____
2. **Body mass index (Normal < 35 Kg/m^2):**_____

Mark all that apply

1. Do you snore excessively?	Yes _____	No _____
2. Do you awaken tired in the morning?	Yes _____	No _____
3. Do you awaken gasping for air?	Yes _____	No _____
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 _____	No _____
7. Do you have high blood pressure?	Yes _____	No _____
8. Do you have difficulty concentrating?	Yes _____	No _____
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 _____	No _____
13. Has anyone witnessed apnea spells during your sleep?	Yes _____	No _____
14. Are you excessively tired during the day? *If "yes" to question 14, answer the following questions*	Yes _____	No _____
Total: (Add each column)		

Would ***never*** doze	***Slight*** chance of dozing	***Moderate*** chance of dozing	***High*** chance of dozing
0	1	2	3

	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)				

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