

## Questionnaire For Snoring/Sleep Apnea

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date \_\_\_\_\_

<b>The Epworth Sleepiness Scale</b>
-------------------------------------

**Situation: (please check appropriate box to right)**

**Chance of dozing:**  
High Medium Low Never

Sitting and reading	_____	_____	_____	_____
Watching TV	_____	_____	_____	_____
Sitting, inactive in a public place (e.g. movie theater or meeting)	_____	_____	_____	_____
As a passenger in a car for an hour without a break	_____	_____	_____	_____
Laying down to rest in the afternoon when circumstances permit	_____	_____	_____	_____
Sitting and talking to someone	_____	_____	_____	_____
Sitting quietly after lunch without alcohol	_____	_____	_____	_____
In the car, while stopped for a few minutes in traffic	_____	_____	_____	_____

\_\_\_\_\_

<b>Behavior During Sleep</b>
------------------------------

**Using the scale below, please select the most appropriate number to answer Question A.**

- 0=never during a usual night
- 1=less than once a week
- 2=once to about half the nights per week
- 3=half the nights per week to almost always
- 4=almost always or every night
- ?=don't know or haven't been told

**A. During your usual sleep, have you noticed or been told that you do the following:**

Snore loudly	_____
Stop breathing	_____
Choke, struggle for breath	_____
Toss and turn frequently	_____
Wake up with a headache	_____
Usual number hours of sleep per night	_____
Number of times you rise to use the toilet	_____