PALMETTO PULMONARY MEDICINE, P.A.
SLEEP QUESTIONNAIRE

Name:_____ Date:_____

Please check yes/no if you have the following:

□ **Yes** □ **No**	Excessive daytime sleepiness?
□ **Yes** □ **No**	Non-refreshing sleep?
□ **Yes** □ **No**	Loud or frequent snoring?
□ **Yes** □ **No**	Frequent night-time awakenings?
□ **Yes** □ **No**	Witnessed apnea events? (Do you stop breathing when you are asleep)
□ **Yes** □ **No**	Cataplexy? (Sudden muscle weakness or falling with laughter/sadness)
□ **Yes** □ **No**	Feelings of paralysis or unable to move upon awakening?
□ **Yes** □ **No**	Visual or auditory hallucinations at the onset of sleep?
□ **Yes** □ **No**	Urge to move, Discomfort, or Disagreeable sensations in arms/legs?
□ **Yes** □ **No**	Do you get up to walk, stretch or massage arms/legs for relief?
□ **Yes** □ **No**	Evening symptoms of leg/arm discomfort or disagreeable sensations.

Please check if you have any of the following:

□ High blood pressure.
□ Heart/coronary artery disease.
□ Congestive heart failure.
□ Atrial fibrillation.
□ Stroke.

How likely are you to doze off or fall asleep in the following situations in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing.
1 = slight chance of dozing.
2 = moderate chance of dozing.
3 = high chance of dozing.

Situation	**Chance of dozing**
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Total Points_____