Campbell County Memorial Hospital Sleep Clinic

Sleep Questionnaire

Name: _____

DOB: _____

Epworth Sleepiness Scale

Scale

0= No chance of dozing 1= Slight chance of dozing 2= Moderate chance of dozing 3= High chance of dozing

How often do you doze?

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting in a public inactive place (theater or meeting)	0	1	2	3
Riding in a car for one hour without a break (as a passenger)	0	1	2	3
Lying down in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch, without alcohol	0	1	2	3
Stopped in traffic for a few minutes	0	1	2	3

Add up the numbers for your total: _____

Symptoms of Obstructive Sleep Apnea

Please circle Yes, No, or comment below

Do you snore?	Yes or No
Has your snoring ever bothered other people?	Yes or No
Do you choke/gasp for breath while you sleep?	Yes or No
Has anyone told you that you stop breathing during sleep?	Yes or No
Do you feel tired or fatigued after you sleep?	Yes or No
Has your weight changed in the last 5 years?	Yes or No
Have you ever nodded off or fallen asleep while driving?	Yes or No
Do you have high blood pressure?	Yes or No

Please Enter/ Circle

Height_____ Weight_____ Age_____ Male/Female