OREGON MEDICAL
WEIGHT LOSS & WELLNESS

# SLEEP QUESTIONNAIRE

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

Please place a check mark next to any of the following symptoms you are experiencing:
_____ Difficulty falling asleep and/or insomnia
_____ Excessive daytime sleepiness and/or fatigue
_____ **Snoring**
_____ Has any bed partner noticed you not breathing while asleep, waking up gasping or choking?
_____ Interrupted sleep patterns
_____ Sleepiness while driving
_____ Frequent morning headaches
_____ Migraines
_____ Hypertension
_____ Diabetes
_____ High cholesterol
_____Obesity
_____ Ear pain
_____ Neck pain
_____ Depression and/or anxiety
_____ Teeth grinding and/or clenching
_____ Leg movements/restless legs

BMI: _____
(Risk if >30)

Neck Circ: _____
(Risk if:
Male >16.5, Women >15)

Questions:
Have you already been previously diagnosed with sleep apnea or another sleep related disorder?_____
If so, how was your condition diagnosed and what treatment did you receive?
_____
_____
If you are using a CPAP device, how often do you use it? Circle one:
every night / almost every night / sometimes / infrequently / never

## EPWORTH SLEEP QUESTIONNAIRE

How likely are you to doze off or fall asleep in the following situations?

| Never = 0 Slight = 1 Moderate = 2 High = 3 | NEVER chance of dozing | SLIGHT chance of dozing | MODERATE chance of dozing | HIGH chance of dozing |
|---|---|---|---|---|
| Sitting and reading | | | | |
| Watching TV | | | | |
| Sitting inactive in a public place (e.g. a theater or a meeting) | | | | |
| As a passenger in a car for an hour without a break | | | | |
| Lying down to rest in the afternoon when circumstances permit | | | | |
| Sitting and talking to someone | | | | |
| Sitting quietly after a lunch without alcohol | | | | |
| In a car, while stopped for a few minutes in traffic | | | | |

Total Score: _____