Sleep Questionnaire

Name:_____

Date:__/__/__ **Your age:** _____ yrs **SEX: Male Female**

How likely are you to doze off or fall asleep in the situations described in the box below in contrast to feeling just tired?

Please **CIRCLE the most appropriate number** for each situation below;

Situation	**Chance of dozing** None	Slight	Moderate	High
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting Inactive in a public place (eg, a theatre or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without Alcohol	0	1	2	3
In a car, while stopped for a few minutes in the traffic	0	1	2	3

Patient Signature_____ **Date:**_____

Partner Questionnaire

Does your partner snore loudly in their sleep? **Yes** ☐ **No** ☐

If YES, **how long have you been aware of this problem?**.....

Has the noise been so bad that you have slept in separate rooms? **Yes** ☐ **No** ☐

If YES, **how often does this occur?**

Every night ☐
3-5 times/week ☐
Less often ☐

Does your partner stop breathing during their sleep? **Yes** ☐ **No** ☐
If YES, **how often does this occur?**

1-10 ☐
11-20 ☐
More than 30 ☐

Is your partner restless in their sleep? **Yes** ☐ **No** ☐
If YES, **how often?**

Sometimes ☐
Often ☐
Always ☐

Have you noticed a change in your partner's behaviour? **Yes** ☐ **No** ☐
If YES, **in what way?**

Does your partner fall asleep easily during the day? **Yes** ☐ **No** ☐
If YES, **in what way?**

Occasionally ☐
If relaxing ☐
Sometimes ☐
Even when busy ☐
Anytime ☐

Information for Patients

Has your partner fallen asleep or become drowsy whilst driving? **Yes** ☐ **No** ☐

Does your partner work particularly long hours? **Yes** ☐ **No** ☐

Please add any other comments overleaf?

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