

QUESTIONNAIRE FOR SNORING

NAME: _____ **DATE:** ____ **AGE:** ____ **SEX:** M F

THE EPWORTH SLEEPINESS SCALE

<p>How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Even if you have not done some of these things recently try to work out how they would have affected you.</p> <p>Use the following scale to choose the most appropriate number for each situation:</p> <p>0 = would never doze</p> <p>1 = slight chance of dozing</p> <p>2 = moderate chance of dozing</p> <p>3 = high chance of dozing</p>	<p>SITUATION</p>	<p>CHANCE OF DOZING (Please circle)</p>
	SITTING AND READING	0 1 2 3
	WATCHING TV	0 1 2 3
	SITTING INACTIVE IN PUBLIC PLACE (E.G. THEATER/MEETING)	0 1 2 3
	AS A PASSENGER IN CAR FOR A HOUR W/O BREAK	0 1 2 3
	LYING DOWN TO REST IN AFTERNOON WHEN CIRCUMSTANCES PERMIT	0 1 2 3
	SITTING AND TALKING TO SOMEONE	0 1 2 3
	SITTING QUIETLY AFTER LUNCH W/O ALCOHOL	0 1 2 3
	IN CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC	0 1 2 3

THE EPWORTH SLEEPINESS SCALE

<p>Use the following scale to choose the most appropriate number for each situation.</p> <p>0 = never during a usual night</p> <p>1 = less than once a week</p> <p>2 = once to about half the night per week</p> <p>3 = half the nights to almost always</p> <p>4 = almost always or every night</p> <p>? = don't know or haven't been told</p>	<p>During your usual sleep have you noticed or have been told you do the following:</p>	<p>(0-4, ?)</p>
	SNORE LOUDLY	0 1 2 3 4 ?
	STOP BREATHING	0 1 2 3 4 ?
	CHOCK, STRUGGLE FOR BREATH	0 1 2 3 4 ?
	TOSS AND TURN FREQUENTLY	0 1 2 3 4 ?
	WAKE UP WITH A HEADACHE	0 1 2 3 4 ?
	USUAL NUMBER HOURS OF SLEEP PER NIGHT	
	NUMBER OF TIMES YOUR RISE TO USE TOILET	

HEIGHT: ____ ft ____ inches

CURRENT WEIGHT: _____ lbs.

WEIGHT GAINED IN LAST 12 MOS. _____ lbs.