SLEEP DISORDER BREATHING QUESTIONNAIRE

**** Please Complete and Return to Your Physician ****

NAME: ______________________________ DATE: ____________________

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

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

	Circle the Appropriate Number Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theater or 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	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch, without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total From Above: _______

Do you often feel tired when awakening from sleep?	o YES	o NO
Do you snore, or has anyone ever told you that you snore?	o YES	o NO
Has anyone ever told you that you stop breathing during sleep?	o YES	o NO
Do you ever have a choking or gasping sensation during sleep?	o YES	o NO
Do your legs "kick" during sleep?	o YES	o NO

** ***PLEASE RETURN COMPLETED FORM TO YOUR PHYSICIAN*** **

If score of 10 or more you may have significant sleep disordered breathing.
You may benefit from further study.

SALEM HOSPITAL
REGIONAL HEALTH SERVICES

SLEEP DISORDERS CENTER
BREATHING QUESTIONNAIRE