SLEEP DISORDERS PATIENT QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

1) What time do you go to bed? __________________________________________

2) How long does it take you to fall asleep once in bed? __________________________

3) While waiting to fall asleep do you feel an unsettled or restless sensation in your limbs (i.e. legs)? YES NO
   - If so do you feel that moving your limbs temporarily relieves this sensation? YES NO

4) Do you kick your legs frequently when you are asleep? YES NO

5) Once asleep, how many times do you awaken during the night? _________________________

6) Do you know what awakens you? ________________________________________________

7) How long does it take you to fall back to sleep? ________________________________

8) Do you awaken with
   (a) a dry mouth YES NO
   (b) nasal congestion? YES NO
   (c) head aches? YES NO
   (d) chest pain? YES NO

9) What time do you awaken in the morning? _________________________________________

10) Do you snore? YES NO

11) Have you been observed to have pauses in your breathing while asleep? YES NO

12) Do you awaken spontaneously or with an alarm clock? ________________________________
   - Do you frequently use the snooze button to extend your sleeping time? YES NO

13) Do you awaken feeling refreshed or fatigued? _____________________________________________

14) Do you consume caffeinated beverages during the day, when and now much? _______________

15) Do you feel sleepy during the day? YES NO

16) Do you take naps during the day or before going to bed? YES NO
   - If so how long and is there a particular time of day? _______________________________

17) To rate your degree of sleepiness during the day please respond to the following:
   How likely are you to doze off or fall asleep during the day in the following situations, in contrast to feeling just tired?

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Watching T.V.</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting, inactive in a public place (i.e. theater)</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td>0 1 2 4</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting quietly after lunch without alcohol</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in the traffic</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

18) Do you have pets in your house?
   18a) Do they ever sleep in your bed? When? __________________________

19) Do you have down or feather pillows, comforter, mattress pad? ______________________________

THANK YOU FOR YOUR TIME