

**Department of Respiratory Medicine
Middlemore Hospital**

SLEEP QUESTIONNAIRE

Your doctor has referred you to the sleep clinic and could you please complete the following sleep questionnaire and return it in the enclosed envelop. The answers you provide will enable us to determine how urgently you need to be seen in the sleep clinic.

Patient label

Address: _____
 (If different from above) _____

T'Phone: (H) _____ (Work) _____ (Mobile) _____

How might we best contact you at short notice? _____

Can we phone you at work? Yes No

If you work, what is your occupation? _____

Are you a night shift worker Yes No

DO YOU DRIVE? – If 'YES', please answer the next three questions Yes No

a) Have you fallen asleep driving in the last two years? Yes No

b) I have had a car accident as a result of falling asleep Yes No

When answering the following questions, if unsure of the response, then please discuss it with your family prior to attempting the questions.

1. I have had an accident at work as a result of falling asleep. Yes No Unsure

2. I have been told that I snore. Yes No Unsure

3. I have been told I stop breathing or hold my breath while I sleep. Yes No Unsure

4. I have trouble staying awake at work. Yes No Unsure

5. I often wake up and have difficulty going back to sleep. Yes No Unsure

6. I lie awake for half an hour or more before I fall asleep. Yes No Unsure

7. I have been told that I kick and jerk during sleep. Yes No Unsure

8. I take pills to help me sleep. Yes No Unsure

9. My current weight is kilos stones + pounds Unsure

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, not just feeling tired? Use the scale to choose the most appropriate number for each situation. Write the number you have chosen in the box to the right of the situation.

- 0 = Would *never* doze/ fall asleep
- 1 = *Slight* chance of dozing/ fall asleep
- 2 = *Moderate* chance of dozing/ fall asleep
- 3 = *High* chance of dozing/ fall asleep

SITUATION

CHANCE OF DOZING (use the scale above)

Sitting and reading	<input type="text"/>
Watching television	<input type="text"/>
Sitting, inactive in a public place (eg a theatre or meeting)	<input type="text"/>
As a passenger in a car for an hour without a break	<input type="text"/>
Lying down to rest in the afternoon when circumstances permit	<input type="text"/>
Sitting and talking to someone	<input type="text"/>
Sitting quietly after a lunch without alcohol	<input type="text"/>
In a car, while stopping for a few minutes in traffic	<input type="text"/>
TOTAL	<input type="text"/>