Name: _____ Date: _____

Date of Birth:_____

SLEEP/WAKE SYMPTOMS AND COMPLAINTS

INSTRUCTIONS: Circle " YES" or "NO" or fill in the blanks as appropriate.

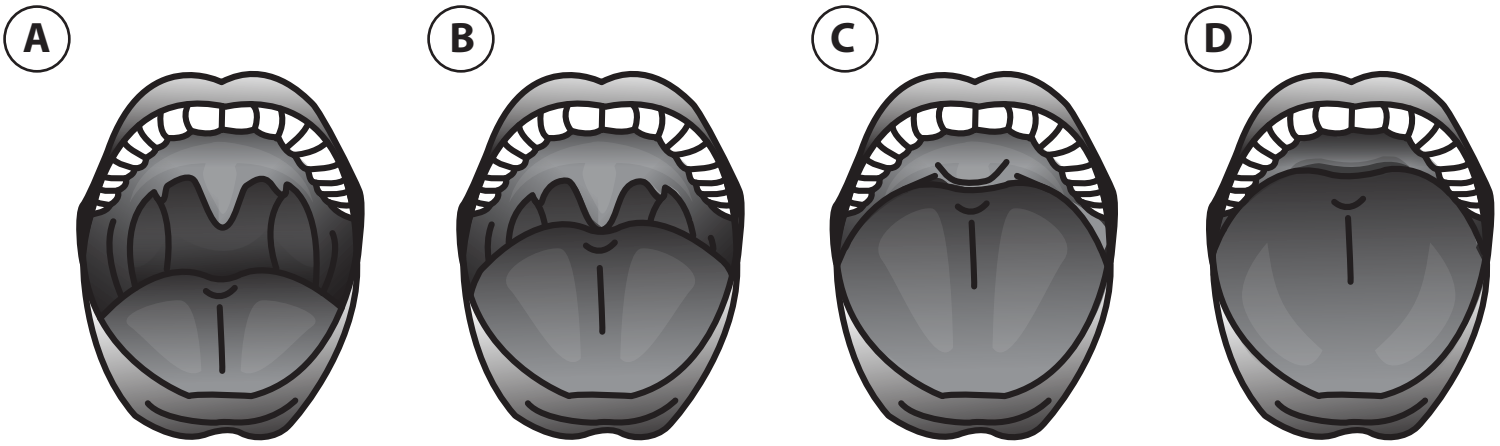
1. Describe your major sleep/wake complaints: _____
   _____
2. What time do you usually go to bed? _____ AM/PM
3. What time do you usually get out of bed? _____ AM/PM
4. Do you have difficulty falling asleep? Yes No
5. Do you wake up often during the night? Yes No
6. Have you been told that you snore? Yes No
7. Have you been told that you stop breathing while asleep? Yes No
8. Do you have a problem with daytime sleepiness? Yes No
9. Do you wake up feeling rested? Yes No
10. Have you ever had a car accident because of sleepiness? Yes No
11. Have you ever had a convulsion (seizure, epilepsy) at night? Yes No
12. Do you usually sleep with a bed partner? Yes No
13. Are you a restless sleeper, tossing and turning at night? Yes No
14. Do you do anything unusual in your sleep (walk, talk, etc.)? Yes No
    If yes, please describe: _____
15. Do you sweat excessively when you sleep? Yes No
16. Do you regurgitate or vomit during the night? Yes No
17. Do you have chest pains during the night? Yes No
18. Do you frequently wake up with headaches? Yes No
19. Have you ever had a head injury? Yes No
    If yes, please describe: _____
20. Do you seem to be losing your sex drive? Yes No
21. Do you have trouble concentrating or remembering things? Yes No
22. Do you feel unusually ill or irritable? Yes No
23. Do you feel short of breath during the day or at night? Yes No
24. Do you suddenly go limp or fall asleep if you are angry, laughing or surprised? Yes No
25. Do you sleep with your head elevated? Yes No
26. Do you usually take naps during the day or evening? Yes No
27. Have you been told your legs kick or move while you sleep? Yes No
28. Do you often have pain, cramps or discomfort in your legs? Yes No
29. Do you often wake with heartburn? Yes No
30. Do you use antacids on a regular basis? Yes No

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (Even if you have not done some of these things recently, try to work out how they would have affected you.) Use the following scale to choose the most appropriate number for each situation.

0-would never doze
1-slight chance of dozing
2-moderate chance of dozing
3-high chance of dozing

SITUATION	**CHANCE OF DOZING**
1. Sitting and reading	_____
2. Watching television	_____
3. Sitting inactive in a public place, such as a theater	_____
4. As a car passenger for an hour without a break	_____
5. Lying down to rest in the afternoon	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped at a traffic light	_____

A score of greater than 10 is a definite cause for concern as it indicates significant excessive daytime sleepiness.



Tonsil Grade =_____ BMI = _____ HT: _____ WT: _____

RDI = 7.816 x MMP + 3.988 x Tonsil Size+ 4.675 x BMI - 7.544 NECK CIRCUMFERENCE