



Patient Name _____

Date of birth _____ / _____ / _____
Month Day Year

This simple test should alert you to problems you may have with your sleep. Check the box beside the number of any statement that may have applied to you over the last year.

- 1. I have difficulty sleeping.
- 2. Thoughts race through my mind and prevent me from sleeping.
- 3. I wake up during the night and have trouble going back to sleep.
- 4. I wake up earlier in the morning than I would like to.
- 5. I sleep better on the weekends.
- 6. I sleep better when traveling than during the week in my own bed.
- 7. I've been told that I snore.
- 8. I suddenly wake up gasping for air during the night.
- 9. I've been told that I stop breathing while sleeping.
- 10. I feel tired or sleepy during the day even though I slept all night.
- 11. I have high blood pressure.
- 12. When I'm angry or surprised, I feel like I'm going limp.
- 13. I experience vivid dream-like scenes upon falling asleep or awakening.
- 14. No matter how hard I try to stay awake, I sometimes fall asleep anyway.
- 15. I feel unable to move when I'm waking or falling asleep.
- 16. I wake up with heartburn.
- 17. I wake up with a bitter or bile taste in my mouth.
- 18. I wake up at night coughing or wheezing.
- 19. I take antacids frequently.
- 20. I have gained weight in the past year.
- 21. I have been told that I kick at night.
- 22. I experience aching or "crawling" sensations in my legs.
- 23. I sometimes can't keep my legs still at night.
- 24. I sometimes have leg cramps that keep me awake or awaken me at night.
- 25. I wake up with sore or stiff muscles.

You may have one of the following sleep disorders if you check symptoms from the groupings noted in parenthesis.

- INSOMNIA..... (Questions 1 through 6)
- SLEEP APNEA (Questions 7 through 11)
- NARCOLEPSY..... (Questions 12 through 15)
- GASTROESOPHAGEAL REFLUX..... (Questions 16 through 20)
- PERIODIC LIMB MOVEMENT DISORDER AND RESTLESS LEGS SYNDROME (Questions 21 through 25)

NAME _____

ADDRESS _____