

Patient Name _____ Acct. # _____

SLEEP QUESTIONS

Do you experience any of the following? Please circle the appropriate answer.

1. Chronic Loud Snoring? Yes No
2. Gasping or choking episodes during Sleep? Yes No
3. Excessive Daytime Sleepiness (especially drowsy when driving)? Yes No
4. Automobile or work-related accidents due to fatigue? Yes No
5. Personality changes or cognitive difficulties related to Fatigue? Yes No
6. Shirt size greater than 17 inches (men only)? Yes No

If you answered yes to any of these questions above, you may be experiencing some type of Sleep Disorder. Please remember to turn in this sheet with your completed packet.