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Sleep Disturbance Questionnaire

Patient Name ______________________________

	Yes	No	Occasionally
Do you have difficulty falling asleep?	___	___	___
Do you wake up during the night?	___	___	___
Do you have discomfort in your legs when lying down?	___	___	___
Do you snore?	___	___	___
Do you awaken with a choking sensation?	___	___	___
Have you been told that you stop breathing when you are asleep?	___	___	___
Are you excessively tired during the day?	___	___	___

How likely are you to fall asleep during the day in the following situations:

0 = would never doze / 1 = slight chance / 2 = moderate chance / 3 = high chance

Situation	**Chance of Falling Asleep**			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e. movie theater)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest during the day when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
While in a car that is stopped	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3