QUESTIONNAIRE - DESCRIPTION OF SLEEP DISORDERS

Name and surname:_____ Telephone number: _____

Weight: ____ kg **Age:** ____ years **Height:** ____ cm

Dear Sir/Madam,

Your sleep disorder description tells a lot about whether diagnostics and treatment are needed and when the problems are already detrimental to your health. For this purpose, please answer the questions below by yourself or with the help of your bed partner. If you do not know the answer to any of the questions, we will discuss it together at the appointment. Please bring your completed questionnaire with you to the appointment.

PART 1

How long does it take for you to fall asleep? From _____ to _____minutes
If you have trouble falling asleep, what distracts your falling asleep?_____
Do you use anything to help you fall asleep (medicine, milk, sleeping tea...)? YES NO
How long do you usually sleep for? During working days _____ hours
During the weekend/on holiday _____ hours
How often do you snore? every night 2-3x a week 2-3x a month rarely
How many times a night do you wake up? several times 1x 2-3x a week 2-3x a month
Why do you wake up at night? _____
How many times do you need to go to the toilet at night?
several times 1x 2-3x a week 2-3x a month
Do you sweat excessively at night? YES NO
How long does it take you to get started with your normal daily activities in the morning?
From ____ to ____ minutes
Do you have frequent headaches in the morning? YES NO
Are you sleepy and tired even before noon? YES NO
Do you wake up more tired in the morning than you were when you went to bed?
YES NO
Do you need daytime rest because of sleepiness? YES NO
If yes, how often? every day 2-3x a week 2-3x a month
Have you ever fallen asleep while driving? YES NO
If so, when and how many times?_____
Do you ever feel sleepy while driving and need to stop to take a nap? YES NO
If you're female, are you in the menopause? YES NO
Have you suffered a heart attack or stroke in the past? YES NO
Do you have a known cardiac rhythm disorder? YES NO
Are you being treated for heart failure? YES NO
Do you have diabetes? YES NO
Do you have a known thyroid disease? YES NO
Are you being treated for a respiratory disease? YES NO

If yes, which one? Asthma COLD Chronic Rhinitis Other: _____

Are you being treated for depression? YES NO

Do you have any other disease? YES NO

If yes, which one? _____

Have you ever had a nose or throat surgery? YES NO

If yes, what kind of surgery was it? _____

PART 2

Do you have high blood pressure or are you being treated for it? YES NO

Is your BMI higher than 35? (weight in kilograms divided by height square in metres) YES NO

Are you over 50 years old? YES NO

Is your neck circumference larger than 40 cm? YES NO

Are you male? YES NO

Answer the following three questions with "YES" only if these problems occur frequently or most days of the week:

Do you snore loudly (louder than you talk or so that people can hear you in another room)? YES NO

Are you often tired, sleepy? YES NO

Has anyone noticed that you stop breathing in your sleep? YES NO

TOTAL NO. OF "YES" ANSWERS IN PART 2 OF THE QUESTIONNAIRE: _____

PART 3

Please answer all 8 questions in the table below. For each question, circle one number from 0 to 3. Then sum the circled numbers and write down your final result on the line below.

What is the likelihood of you falling asleep during the FOLLOWING SITUATIONS? (0 - I do not fall asleep, 1 - moderate, 2 - medium, 3 - high)				
When you read sitting down?	0	1	2	3
When you watch TV?	0	1	2	3
When you sit in a public place (theatre, waiting room...)?	0	1	2	3
When you are a passenger in a car, and driving for more than 1 hour?	0	1	2	3
When you lie down to have an afternoon rest?	0	1	2	3
When you sit down and talk?	0	1	2	3
When you sit still after lunch?	0	1	2	3
When you are in the car and stop for a few minutes in traffic?	0	1	2	3

SUM OF CIRCLED NUMBERS OF PART 3 OF THE QUESTIONNAIRE: _____