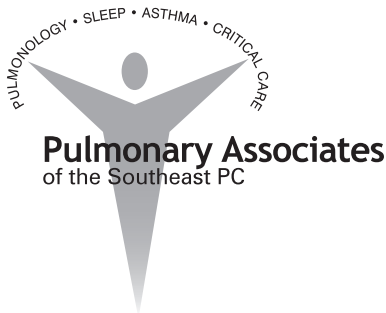


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SLEEP DISORDER QUESTIONNAIRE

Name _____ DOB _____

1. During the week, what time do you normally go to sleep? _____

2. During the week, what time do you normally wake up? _____

3. On your weekends, or during your time off, do you sleep more than you do during the week? _____

4. Do you have memory lapses? _____

5. Do you have difficulty concentrating? _____

6. Do you find that you are sleepy all the time? _____

7. Do you fall asleep when you are trying to watch television, read a book, or perform other tasks? _____

8. Do you have trouble falling asleep? _____

9. Do you nap during the day? _____

10. If so, how many times do you nap and for how long? _____

11. Do you drink alcohol, and if so how much? _____

12. Do you consume foods with caffeine (soft drinks, tea, coffee, chocolate? If so how much? _____

13. Do you use tobacco? If so, how much? _____

14. Do you feel there is undue stress in your life now? _____

15. Do you exercise close to bedtime or perform tasks requiring a lot of mental concentration before bedtime? _____

16. Do you snore? _____

17. Have you been told by a bed partner that you stop breathing during sleep? _____

18. Have you been told by a bed partner that you move your legs about or kick excessively during sleep? _____

19. Do you have cramping, pulling, or other disagreeable sensations in your legs when relaxing or trying to sleep? _____

20. Have you experienced any weakness in the legs during periods of excitement or stress? _____