

# Initial Evaluation Questionnaire

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo. Day Year

Code Number: \_\_\_\_\_

Sex:  1 Male  2 Female

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_  
Mo. Day Year

Marital Status:  01 Single  05 Widowed  
 02 Married  06 Divorced and remarried  
 03 Divorced  07 Domestic partner  
 04 Separated

Race:  1 Caucasian  3 Asian  5 Other (specify): \_\_\_\_\_  
 2 African American  4 Hispanic

Is there usually a bed partner to observe your sleep?:  1 Yes  2 No

## During the last week:

	Never	Rarely	Some- times	Often
1. Have you snored or have you been told that you do?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. Have you had choking or shortness of breath sensations at night?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. Have you woken up during sleep?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. Have you had morning fatigue or fogginess or woken up feeling unrefreshed?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. Have you woken up with a headache?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. Have you had chronic sleepiness, fatigue or weariness that you can't explain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. Have you fallen asleep during the day, particularly when not busy?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8. Have you fallen asleep reading or watching television?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9. Have you fallen asleep during the day against your will?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10. Have you had to pull off the road while driving due to sleepiness?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
11. Have you been more irritable and short-tempered?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
12. Have you felt your memory and/or intellect is impaired?	<input type="checkbox"/> 1 Yes		<input type="checkbox"/> 2 No	
13. Have you been told that you stop breathing while asleep?	<input type="checkbox"/> 1 Yes		<input type="checkbox"/> 2 No	