

Sleep Disorders Center of Key West

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SCREENING QUESTIONNAIRE

Please complete and return to your physician.

Name: _____

Date: _____

How likely are you to doze off or fall asleep in the following situations?

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Circle the appropriate number

Situation	Chance of dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g., a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch, without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total from above: _____ (>10?)

Do you often feel sleepy during the daytime? Yes No

Do you snore, or has anyone ever told you that you snore? Yes No

Has anyone ever told you that you stop breathing during sleep? Yes No

Do you ever have a choking or gasping sensation during sleep? Yes No

Do your legs 'kick' during sleep? Yes No

Thank you!