Initial Evaluation Questionnaire

Date: ____/____/________ Code Number.___________

MO. Day Year

Sex: ☐ 1 Male ☐ 2 Female

Date of Birth : ____/____/________ Age: ___________

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

Race:
- ☐ 1 Caucasian
- ☐ 2 African American
- ☐ 3 Asian
- ☐ 4 Hispanic
- ☐ 5 Other (specify) ____________________________

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 been told that you do?	☐1	☐2	☐3	☐4
2. Have you had choking or shortness of breath sensations at night?	☐1	☐2	☐3	☐4
3. Have you woken up during sleep?	☐1	☐2	☐3	☐4
4. Have you had morning fatigue or fogginess or woken up feeling un-refreshed?	☐1	☐2	☐3	☐4
5. Have you woken up with a headache?	☐1	☐2	☐3	☐4
6. Have you had chronic sleeplessness, fatigue or weariness that you Can't explain?	☐1	☐2	☐3	☐4
7. Have you fallen asleep during the day, particularly when not busy?	☐1	☐2	☐3	☐4
8. Have you fallen asleep reading or watching television?	☐1	☐2	☐3	☐4
9. Have you fallen asleep during the day against your will?	☐1	☐2	☐3	☐4
10. Have you had to pull off the road while driving due to sleepiness?	☐1	☐2	☐3	☐4
11. Have you been more irritable and short tempered?	☐1	☐2	☐3	☐4
12. Have you felt your memory and / or intellect is impaired?	☐1	☐2	☐3	☐4
13. Have you been told that you stop breathing while sleeping?	☐1	☐2	☐3	☐4