

## Expert Sleep Quiz

**Symptoms (Please circle all that apply)**

**Height\_\_\_\_\_ Weight\_\_\_\_\_**

Sleepiness	Insomnia	Movement while asleep	Restless Sleep
Multiple awakenings	Sleep walking	Fatigue	Mood disorder
Sleep talking	Snoring	Poor Brain function	Acting out dreams
Witnessed Apnea	Restless legs	Abnormal dreams	Are you on CPAP/BiPAP

### Sleep Hygiene/Habits

Do you awaken short of breath at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone told you that you stop breathing at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you awaken feeling tired or fatigued?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have excessive daytime sleepiness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does work intrude on your sleep pattern or schedule?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does leg movement or pain awaken you at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you sleep talk or walk?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you "act" out your dreams?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have trouble going to and staying asleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you get less than 7 hours of sleep every night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
When you are going to sleep or awakening, are you temporarily paralyzed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you ever feel weak when expressing a strong emotion (fear, laughter?)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you wake up at night, does it take a long time to fall asleep again?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel the need to nap	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have the different sleep schedule during the week due to work	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you sleep longer on the weekend	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your work schedule interfere with your sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you work when your body clock would prefer that you sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No

**What was your Epworth Sleepiness Scale (> 10 is abnormal, see back)\_\_\_\_\_**

**What is your STOPBANG score (>3 is abnormal, see back)\_\_\_\_\_**

## STOP BANG Questionnaire

- |                              |                                                                                            |        |
|------------------------------|--------------------------------------------------------------------------------------------|--------|
| 1. <b>Snoring</b>            | Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? | Yes No |
| 2. <b>Tired</b>              | Do you often feel tired, fatigued, or sleepy during daytime?                               | Yes No |
| 3. <b>Observed</b>           | Has anyone observed you stop breathing during your sleep?                                  | Yes No |
| 4. <b>Blood pressure</b>     | Do you have or are you being treated for high blood pressure?                              | Yes No |
| 5. <b>BMI</b>                | BMI more than 35 kg/m <sup>2</sup> ? **                                                    | Yes No |
| 6. <b>Age</b>                | Age over 50 yr old?                                                                        | Yes No |
| 7. <b>Neck circumference</b> | Neck circumference greater than 15 in (female) 17 in (male)?                               | Yes No |
| 8. <b>Gender</b>             | Gender male?                                                                               | Yes No |

**High risk of OSA: answering yes to three or more items**

**Low risk of OSA: answering yes to less than three items**

**\*\* to find BMI go to [expertsleep.com](http://expertsleep.com)>obesity>BMI**

**Total Yes answers** \_\_\_\_\_

## THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in these situations? This refers to your usual way of life in recent times. Even if you have not done some of these things recently. Try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

<u>Situation</u>	<u>Chance of Dozing</u>	<u>Scale</u>
1. Sitting and Reading	0 1 2 3	0 = would never doze
2. Watching TV	0 1 2 3	1 = slight chance of dozing 2 = moderate chance of dozing
3. Sitting inactive in a public place	0 1 2 3	3 = high chance of dozing
4. As a passenger in a car for an hour without a break	0 1 2 3	
5. Lying down to rest in the afternoon when circumstances permit	0 1 2 3	
6. Sitting and talking to someone	0 1 2 3	
7. Sitting quietly after lunch (without alcoholic beverage)	0 1 2 3	
8. In a car while stopped for a few minutes in traffic	0 1 2 3	

**Epworth Sleepiness Total** \_\_\_\_\_