HOAG MEMORIAL HOSPITAL PRESBYTERIAN

SLEEP OBSERVER QUESTIONNAIRE

Patient Name: _____ Date: _____

1. How long have you observed the patient's sleep? _____

2. Check any of the following that you have observed in the patient:

While Asleep	While Awake
☐ light snoring	☐ morning headache
☐ loud snoring	☐ morning sluggishness
☐ "World Class" snoring	☐ morning confusion
☐ twitching/kicking of legs or feet	☐ excessive sleepiness
☐ pause in breathing	☐ fainting episodes
☐ pause in breathing w/loud "snorts"	☐ napping
☐ grinding teeth	☐ asleep at theater/movies
☐ sleep talking	☐ asleep watching TV
☐ sleep walking	☐ asleep in car
☐ bed-wetting	☐ asleep on telephone
☐ sitting up in bed but not awake	☐ asleep reading
☐ becoming very rigid and/or shaking	☐ asleep at unusual times

3. Describe the sleep and wake behavior(s) checked above in more detail. Include a description of the activity, time(s) of the night/day it usually occurs, and how many times per week it occurs. If you need more room, please use the back of this sheet.

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_____

_____ _____ _____ A.M./P.M
[Completed By] [Date] [Time]

_____
[Indicate Relationship to patient]

SLEEP OBSERVER QUESTIONNAIRE
Sleep Disorders Center
PS 1704 Rev 07/02/10

[2459]

Patient Label