FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE
Hoag Sleep Health Program

Patient Name: _____ Date of Birth: _____

Directions: Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired. Please draw a circle around your answer for each question. All information will be kept confidential.

1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?

   1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

2. Do you generally have difficulty remembering things because you are sleepy or tired?

   1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?

   1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

4. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?

   1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

5. Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?

   1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

6. Has your relationships with family, friends or work colleagues been affected because you are sleepy or tired?

   1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

7. Do you have difficulty watching a movie or video because you become sleepy or tired?

   1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?

   1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?

   1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

10. Has your intimate or sexual relationships been affected because you are sleepy or tired?

    1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Patient/Legal Representative Signature: _____ Date: _____

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____