THE SLEEP CENTER
OF SOUTHERN CALIFORNIA

SLEEP SURVEY

Your answers to the following preliminary sleep survey will help our sleep medicine specialists determine the appropriate course of treatment.

Name: _____ **Date:** _____

DOB: _____ Age: _____ Weight: _____ Gender: Female ❒ Male❒

Do you **snore**? (loud enough to be heard through closed doors)……..……..... ❒Yes ❒No

Do you feel **tired**, fatigued, or sleepy during the day? ……..... ❒Yes ❒No

Has anyone **observed** you stop breathing while you sleep? ……..... ❒Yes ❒No

Are you being treated for high blood **pressure**? …… ❒Yes ❒No

Do you have trouble with concentration or memory? …… ❒Yes ❒No

Do you have occasional morning headaches? …… ❒Yes ❒No

Do you fall asleep in meetings, while reading, watching TV or driving? ……..... ❒Yes ❒No

Do you suffer from depression or mood changes? ……..... ❒Yes ❒No

Do you have trouble going to sleep or staying asleep? ……. ❒Yes ❒No

Do you experience an aching, crawling or uncomfortable feeling in your legs when you're trying to sleep? …… ❒Yes ❒No

How would you rate your sleep? ……...…… ❒POOR ❒FAIR ❒GOOD

Do you have High Blood Pressure? …… ❒Yes ❒No

Do you have Heart Disease? …….. ❒Yes ❒No

Have you had a Stroke? ……. ❒Yes ❒No

Do you have Sleep Apnea? …… ❒Yes ❒No

If you have answered "yes" to 2 or more questions on this survey, please contact The Sleep Center to schedule a preliminary consultation. A referral from your Primary Care Physician is needed in most cases.

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