Sleep Smart

Name: ____ Date: ____________

Signs and Symptoms

Please check **all** of the following signs and symptoms which apply to you

_______Heavy snoring

_______Snoring interrupted by Silence and then gasping

_______Forgetfulness

______ Anxiety/Depression

______ High Blood Pressure

______ Restless Sleep

______Trouble Concentrating

______ Loss of Libido

_______Short Temper

_______Irritability

_______Loss of Energy

______ Fatigue

_______Morning Headaches

______ Falling asleep at inappropriate times

Epworth Sleepiness Scale

How likely are you to doze-off or fall asleep in the following situations, in contrast to just feeling tired? 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 select the most appropriate number for each situation)

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of dozing
Sitting and reading	______
Watching T.V.	______
Sitting, inactive in a public place (theatre or meeting)	______
As a passenger in a car for an hour without a break	______
Lying down to rest in the afternoon when circumstances permit	______
Sitting and talking to someone	______
Sitting quietly after a lunch without alcohol	______
In a car, while stopped for a few minutes in traffic	______
Total	______