Take this Sleep Assessment Quiz

Place a check mark next to any of the following that apply to you and include the infomation indicated. Take this sleep quiz with you to your doctor's appointment.

- ☐ Do you snore most nights?
  How loudly? _____
- ☐ Do you experience or have been told that you gasp for breath or stop breathing during sleep?
- ☐ Do you feel sleepy during the day or fall asleep when reading, watching TV or are engaged in daily activities?
- ☐ Have you fallen asleep or dozed off when driving or while at work or school?
- ☐ Do you have difficulty falling or staying asleep.
  How often? _____
- ☐ Do you wake up often feeling tired and not rested?
  How many hours do you usually sleep at night? _____
- ☐ Do you keep a regular bedtime and wake-time?
- ☐ Do you often have disruptions to your sleep?
  Due to any cause? _____
- ☐ Are you taking any sleeping pills or other treatments to help you sleep?
  What medications or supplements you are taking? _____
  _____
- ☐ Do you use alcohol or smoke regularly?
  What time of day you use caffeine products, exercise and eat your last meal?
  _____
- ☐ Do you experience nighttime heartburn, pain or the need to urinate?
  What is your level of stress and have you experienced lifestyle changes recently?
  _____