



**NORTHSHORE
SLEEP MEDICINE**

Northshore Sleep Medicine Screening Questionnaire

1. Do you have trouble falling or staying asleep? Yes No
2. Do you often feel tired or sleepy when you should feel alert? Yes No
3. Have you ever nodded off at an inappropriate time, such as while driving? (Please answer yes if you have nodded off while stopped in traffic or at a light.) Yes No
4. Do you often wake up with a headache, or feeling groggy, or not refreshed? Yes No
5. Do you snore or have you been told you snore? Yes No
6. Have you ever been told that you choke, gasp, or stop breathing while you're sleeping? Yes No
7. Do you have problems with memory, concentration, or irritability? Yes No
8. Do you ever get unusual, uncomfortable sensations in you legs, usually occurring later in the evening that are relieved by moving your legs? Yes No
9. Have you ever been told you kick or move a lot during sleep? Yes No
10. Do you ever act out your dreams while sleeping? Yes No

If you have answered yes to any of these questions, you may have a serious sleep disorder. Please call Dr. Lisa Shives to schedule an evaluation.

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