

HILLCROFT MEDICAL CLINIC SLEEP CENTER

Sleep Disorders Symptom Checklist (Self Test)

	OFTEN	SOMETIMES	NEVER
1. Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has anyone noticed you stopped breathing during sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you woke up with dry mouth or sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever awakened gasping for air?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you awaken feeling un-rested?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you ever awaken with a headache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you sleepy during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you feel tired or fatigued during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have difficulty staying awake while driving or at work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you restless and disturbed at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I snore loudly enough that my spouse or others complain about it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever experienced a sudden loss of muscle tone when laughing, angry or excited?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you ever have vivid dream-like experiences when falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I am bothered by frequent awakenings during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you ever experienced paralysis when going to sleep or upon awakening?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you ever experience a restless or crawling sensation or cramps in your legs at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever been told your legs jerk, twitch or kick during sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you walk in your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I awaken from sleep short of breath.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you grind your teeth in your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Do you experience bad dreams or nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. My mind is not working as quickly and effectively as it used to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you ever awakened with a sense of dread and not known the reason why?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. My sleep is disturbed by heartburn, chocking or acid reflex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you find it necessary to take medication or drink alcohol to fall asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you have difficulty falling asleep and staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have any of these symptoms, complete this checklist and discuss you options with your physician or you my call HMC Sleep Center **713-273-5838** for assistance.

Name of Patient _____ Phone _____