

Sleep Disorders

Screening

Are You Experiencing Any Of The Following?

	YES	NO
Loud snoring	<input type="checkbox"/>	<input type="checkbox"/>
Excessive daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime bedwetting	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime sweating	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss/impairment	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime awakenings/insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Job performance issues from sleepiness	<input type="checkbox"/>	<input type="checkbox"/>
Falling asleep at stop signs and lights	<input type="checkbox"/>	<input type="checkbox"/>
Waking up coughing/choking/heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Morning headaches	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure and/or diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in legs and/or ankles/feet	<input type="checkbox"/>	<input type="checkbox"/>

If you answered **YES** to any **2 or more** questions, you may have a sleep-related breathing disorder. Discuss this questionnaire with your physician.



MethodistSM
Healthcare

Sleep Disorders Center



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