

Name: _____
D.O.B.: _____
Height: _____ Wt: _____

- 1. I have difficulty falling asleep.
- 2. Thoughts race through my mind and this prevents me from sleeping
- 3. I am afraid to go to sleep.
- 4. I wake up during the night and can't go back to sleep.
- 5. I worry about things and have trouble relaxing.
- 6. I wake up earlier in the morning than I would like to.
- 7. I lie awake for a half an hour or more before I fall asleep.
- 8. I feel sad and depressed.
- 9. I've been told that I snore.
- 10. I've been told that I stop breathing while I sleep, although I don't remember this when I wake up.
- 11. I have high blood pressure.
- 12. My family and friends say that they have noticed a change in my personality.
- 13. I am gaining weight.
- 14. I sweat excessively during the night.
- 15. I have noticed my heart beating irregularly or pounding during the night.
- 16. I have morning headaches.
- 17. I have trouble sleeping when I have a cold.

- 18. I suddenly wake up unable to breathe during the night.
- 19. I am overweight.
- 20. I have lost interest in sex.
- 21. I feel sleepy during the daytime.
- 22. I have fallen asleep at school or church.
- 23. When I get angry or surprised, my body feels limp.
- 24. I have fallen asleep while driving.
- 25. I remember vivid dreams as I fall asleep.
- 26. I feel like I am walking around in a daze.
- 27. I have fallen asleep while working.
- 28. I have fallen asleep when laughing or crying.
- 29. I have fallen asleep while eating.
- 30. I feel like I have to cram activities into every hour to get work done.
- 31. I nap frequently and wake refreshed.
- 32. I fall asleep no matter how hard I try to stay awake.
- 33. I remember having vivid nightmares when I go to sleep.
- 34. I have felt like I can't move when I fall asleep or wake up.

- 35. I fall asleep during the day even though I feel I have slept enough the night before.
- 36. I wake up at night with heartburn.
- 37. I have a chronic cough.
- 38. I wake up frequently with a dry mouth.
- 39. I use antacids almost every week for stomach trouble.
- 40. I wake up at night wheezing or coughing.
- 41. I frequently have sore throats.
- 42. During the night, I suddenly wake up and am unable to go back to sleep.
- 43. I have muscle cramps in my legs.
- 44. I often feel that "I have to move my legs" and can't keep them still.
- 45. I have been told that I kick my legs throughout the night.
- 46. I awaken with sore "achy" muscles.
- 47. I awaken with leg pains at night.
- 48. Even though I have slept eight hours, I am sleepy at various times in the day.
- 49. In the morning when I awaken, my bed covers are a mess.
- 50. I frequently feel muscle tension in my legs even when I'm not exercising.

Score Yourself...

Questions 1 through 8:

If you marked three or more boxes, you show symptoms of **INSOMNIA**; an inability to fall asleep or stay asleep.

Questions 9 through 21:

If you marked three or more boxes, you show symptoms of **SLEEP APNEA**; a life threatening disorder which causes you to stop breathing while you sleep.

Questions 22 through 35:

If you marked three or more boxes, you show symptoms of **MARCOLEPSY**; a lifelong disorder characterized by uncontrolled sleep attacks during the day.

Questions 36 through 42:

If you marked three or more of the boxes you show symptoms of **GASTROESOPHAGEAL REFLUX**; a disorder caused when acid in the stomach "backs up" into the esophagus at night.

Questions 43 through 50:

If you marked three or more boxes, you show symptoms of **RESTLESS LEG SYNDROME**; a disorder characterized by pain or "crawling" sensations in the legs.

If you show symptoms of any of the sleep disorders listed above, contact

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Sleep Quiz

Do you snore?

Do you have trouble sleeping?

Are you tired all the time?

One out of three Americans has a sleep disorder. Many of these people suffer needlessly because they are unaware that a problem exists. Once detected, most sleep disorders can be corrected.

This simple quiz is designed to alert you to any problems resulting from poor quality sleep. If you have experienced any of the following symptoms in the last year, check the box beside the number.