NHS Dorset Sleep Service

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NHS
Dorset County Hospital
NHS Foundation Trust

Short Sleep Questionnaire

Patient Details

***First Name:**			
***Last Name:**			
***NHS Number:**			
***Date of Birth:**		***Gender:** ☐ Female ☐ Male ☐ Non-Binary	
***Address:**			
Accessibility Needs:			

Sleep and Sleepiness Questions

Do you have or do any of these things more than three times a week?

1	Excessive or loud snoring	☐ Yes	☐ No
	Stopping breathing when asleep	☐ Yes	☐ No
	Waking gasping for breath or choking	☐ Yes	☐ No
	Disturbed or broken sleep (frequent awakenings)	☐ Yes	☐ No
	Unable to get to sleep (insomnia)	☐ Yes	☐ No
	Unable to get enough sleep (waking too early)	☐ Yes	☐ No
	Morning headaches	☐ Yes	☐ No

2	Unrefreshing sleep or always feeling tired	☐ Yes	☐ No
	Sleeping too long (struggling to wake up)	☐ Yes	☐ No
	Struggling to concentrate on daily tasks	☐ Yes	☐ No
	Being more irritable or emotional than usual	☐ Yes	☐ No
	Taking deliberate daytime naps	☐ Yes	☐ No
	Taking unintentional daytime naps	☐ Yes	☐ No
	Falling asleep in inappropriate situations (in conversation, in public, at work, etc.)	☐ Yes	☐ No

3	Restless legs in the evenings	☐ Yes	☐ No
	Twitching and jerking movements during sleep	☐ Yes	☐ No
	Excessive sleep movement or sleep talking (e.g., flailing limbs, shouting out)	☐ Yes	☐ No
	Sleepwalking or acting out dreams	☐ Yes	☐ No
	Night terrors or disturbing dreams	☐ Yes	☐ No
	Episodes of sleep paralysis (mind is awake but body cannot move)	☐ Yes	☐ No
	Sudden weakness of limbs when laughing or feeling emotional (cataplexy)	☐ Yes	☐ No

Short Sleep Questionnaire

Epworth Sleepiness Scale

Think about your daily life over the past 2 weeks. What is the chance that you may doze off in these situations?

	(0) No chance of dozing	(1) Slight chance of dozing	(2) Moderate chance of dozing	(3) High chance of dozing
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place	☐	☐	☐	☐
As a passenger in a car for an hour	☐	☐	☐	☐
Lying down to rest in the afternoon	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch	☐	☐	☐	☐
Whilst driving and stopped in traffic	☐	☐	☐	☐
TOTAL:				

STOPBANG Score

Do you snore loudly enough to be heard through a closed door?	☐ Yes	☐ No
Do you often feel tired, lethargic, or sleepy in the daytime?	☐ Yes	☐ No
Has anyone said you stop breathing or choke/gasp in your sleep?	☐ Yes	☐ No
Do you have high blood pressure or are you on treatment for it?	☐ Yes	☐ No
Is your BMI more than 35?	☐ Yes	☐ No
Is your age more than 50?	☐ Yes	☐ No
Is your collar size more than 16in / 40cm?	☐ Yes	☐ No
Are you male?	☐ Yes	☐ No
TOTAL:		

Additional Information

Working Status	Does your work involve any of the following?
☐ Retired or not working at the moment	☐ Driving as part of job description
☐ Working part-time	☐ Operating heavy machinery
☐ Working full-time	☐ Long periods of sustained concentration for safety
☐ Working multiple jobs or significant overtime	☐ None of these or N/A

Driving Status	Do you have any of the following?
☐ Do not drive	☐ Heart or lung failure, or chronic kidney disease
☐ Currently not driving, but wish to in future	☐ Heart arrythmia (irregular heartbeat)
☐ Current driver for commuting or personal trips	☐ Epilepsy or seizures
☐ Professional driver (HGV, bus, taxi, etc)	☐ None of these