General questions

We would like to ask you to complete the following questionnaire to clarify your findings.
Please tick the appropriate box. Many Thanks.

Name ..... First Name ..... Date of birth .....

Address ..... Phone .....

1. Are you tired during the day?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

2. Do you fall asleep during the day?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

3. Is it hard for you to stay focused for a long time?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

4. Do you feel limited in your performance lately?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

5. Does it happen that you fall asleep badly in the evening?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

6. Does it happen that you wake up in the middle of the night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

7. Does it happen that you wake up earlier than usual?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

8. Do you feel heart stumbling, tachycardia at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

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19. Are you limited in your capacity due to shortness of breath if you do not do any physical work?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

20. Has your partner noticed respiratory arrest at night? ☐ **I do not have a partner**

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

21. Do you wake up fresh and rested in the morning?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

22. Do you feel limp and skidded in the morning?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

23. Do you have a headache in the morning?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

24. Does your partner report that you are snoring loudly and irregularly?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

25. Does your partner report that you move frequently at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

26. Do you tend to fall asleep while driving?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

27. Have you recently caused a car crash or a small damage?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

28. Do you sleep longer than before? / What are your sleep times?

☐ Yes	☐ No	Mostly sleep at ..... o'clock.	Wake up in the morning at .....

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9. Are you wet with sweat at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

10. Do you have shortness of breath, feelings of suffocation at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

11. Do you feel a headache at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

12. Do you feel coughing at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

13. Do you feel pressure in the chest at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

14. Do you need to go to the toilet at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

15. If you suffer from sleep disorders, can you think of a reason?

☐ no	☐ Yes, physical	☐ Noises, noise	☐ Work problems	☐ Shift-Nightwork	☐ Excitement, Nervousness	☐ Other complaints ....

16. Are your legs swollen?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

17. Are you limited in your capacity to exercise due to shortness of breath when performing heavy physical work?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

18. Are you limited in your capacity to exercise due to shortness of breath when doing light physical work?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

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29. Do you take sleeping pills?

☐ Yes ☐ No If yes, which ..... ☐ rare ☐ occasionally ☐ often ☐very often

30. Do you have high blood pressure?

☐ Yes ☐ No If yes, how high: ..... / ..... (mmHg) ☐ I don't know

31. Do you smoke cigarettes?

☐ No ☐ Yes, up to 10 cigarettes ☐ Yes, up to 20 cigarettes ☐ Yes, over 21 cigarettes

32. Please state your body weight and size

Body weight: ..... kg Body size: ..... cm

33. Are you working?

☐ Yes, I am ..... (occupation / Activity) ☐ No ☐ Retired

34. Which medications do you take and how often?

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35. Do you have any other illnesses?

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Date ..... Signature .....

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