

SLEEP **muskegon** STOP SNORING!

Sleep Observer Scale

PATIENT NAME _____

OBSERVER NAME _____

DATE

This questionnaire asks questions about behaviors that you have observed in this patient in various situations. Your observations do not need to be a single night's behavior, it is better to indicate a summary or average of behaviors you've observed over multiple nights.

Choose the appropriate score or frequency for each situation.

- 0 = Never
- 1 = Infrequently
- 2 = Frequently
- 3 = Very Regularly

1. Very loud irritating snoring
2. Snoring requiring separate bedrooms
3. Choking or gasping during sleep
4. Pauses in breathing during sleep
5. Waking up during sleep frequently
6. Restless tossing and turning
7. Twitching / Kicking of arms or legs
8. Excessive sleepiness during the day (Falling asleep easily or in inappropriate situations)