Weight _____ Weight prior to surgery? _____

Do you snore? ☐ Yes ☐ No How often? _____(days/week)

How loudly (scale 0–10)? _____ How long have you been a snorer? _____

How has your snoring changed since surgery? _____

Weekday bedtime and wake up time: _____ Weekend:_____

How long does it take you to fall asleep at night? _____

How many times do you wake up at night? _____ How long to fall back asleep? _____

Feel refreshed when you wake up in the morning? _____

Does fatigue limit your daily activities? ☐ No ☐ Mild ☐ Moderate ☐ Severe

How have your sleep quality and fatigue changed since surgery? _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep (in contrast to feeling tired) in the following situations? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Choose the following scale to choose the most appropriate number for each situation.

0 would never doze
1 slight chance of dozing
2 moderate chance of dozing
3 high chance of dozing

SITUATION	CHANCE OF DOZING			
	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching television	☐	☐	☐	☐
Sitting inactive in a public place (for example, a movie theater or meeting)	☐	☐	☐	☐
As a passenger in a car for an hour, without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE

Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleep or tired. In this questionnaire, when the words “sleepy” or “tired” are used, it means the feeling that you can’t keep your eyes open, your head is droopy, that you want to “nod off,” or that you feel the urge to take a nap. These words do **not** refer to the tired or fatigued feeling you may have after you have exercised.

DIRECTIONS: Please put an X in the box for your answer to each question. Select only **one** answer for each question. Please try to be as accurate as possible. All information will be kept confidential.

	(0) I don’t do this activity for other reasons	**(4)** No difficulty	**(3)** Yes, a little difficulty	**(2)** Yes, Moderate difficulty	**(1)** Yes, Extreme difficulty
1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?	☐	☐	☐	☐	☐
2. Do you generally have difficulty remembering things because you are sleepy or tired?	☐	☐	☐	☐	☐
3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐	☐
4. Do you have difficulty operating a motor vehicle for longer distances (greater than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐	☐
5. Do you have difficulty visiting with your family or friends in their home because you become sleepy or tired?	☐	☐	☐	☐	☐

	(4) No	(3) Yes, A little	(2) Yes, Moderately	(1) Yes, Extremely	
6. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?	☐	☐	☐	☐	
	(0) I don't do this activity for other reasons	**(4)** No difficulty	**(3)** Yes, a little	**(2)** Yes, Moderate difficulty	**(1)** Yes, Extreme difficulty
7. Do you have difficulty watching a movie or video because you become sleepy or tired?	☐	☐	☐	☐	☐
8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?					
9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?					
10. Has your desire for intimacy or sex been affected because you are sleepy or tired?					

Thank you for completing this questionnaire.