PHYSICIANS EAST P.A.
Sleep Center
Sleep Well. Live Well.

Do I Need a Sleep Evaluation?

Name: _____

Address: _____

Height: _____ Weight: _____

Age: _____ Sex: Male

☐ Do you have trouble falling asleep?

☐ Do you have trouble staying asleep?

☐ Do you have a creepy, crawly feeling in your legs?

☐ Do you get a good night's sleep and still feel tired during the day?

☐ Do you fight to stay awake during the day?

☐ Do you wake up with headaches?

☐ Do you need to take naps during the day?

☐ Have you been told you snore or have woken yourself up snoring?

☐ Has someone witnessed you stop breathing or struggling to breathe while you were sleeping?

☐ Have you woken up from sleep to catch your breath?

If you answered Yes to any of these questions, you may benefit from a sleep study. Please print out this sheet, with your answers, and take it with you to see your physician.