SLEEP APNEA QUALITY OF LIFE QUESTIONNAIRE (SAQLI)

Response #	Description
7	Not at all
6	A small amount
5	A small to moderate amount
4	A moderate amount
3	A moderate to large amount
2	A large amount
1	A very large amount

Situations:	Response # from above
1. How much have you had to push yourself to remain alert during a typical day? (e.g. work, school, childcare, housework)	
2. How often have you had to use all of your energy to accomplish your most important activity? (e.g. work, school, childcare, housework)	
3. How much difficulty have you had finding the energy to do other activities? (e.g. exercise, relaxing activities)	
4. How much difficulty have you had fighting to stay awake?	
5. How much of a problem has it been to be told that your snoring is irritating?	
6. How much of a problem have frequent conflicts or arguments been?	
7. How often have you looked for excuses for being tired?	
8. How often have you not wanted to do things with your family and/or friends?	
9. How often have you felt depressed, down or hopeless?	
10. How often have you been impatient?	
11. How much of a problem has it been to cope with everyday issues?	
12. How much of a problem have you had with decreased energy?	
13. How much of a problem have you had with fatigue?	
14. How much of a problem have you had with waking up feeling unrefreshed?	
TOTAL:	

Patient Name: _____ DOB: _____

THE EPWORTH SLEEPINESS SCALE

Name: _____ Age: _____ Gender: M / F Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? 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 have affected you. Use the following scale to choose the most appropriate number for each situation. Please circle your response:

0 – Would never doze	1 – Slight chance of dozing	2 – Moderate chance of dozing	3 – High chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and Reading	0 1 2 3
Sitting inactive in a public place (e.g. a theatre or meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking with someone	0 1 2 3
Sitting quietly after lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in traffic	0 1 2 3
Watching T.V.	0 1 2 3

Name of person completing this form: _____

Signature: _____

Relationship (if other than patient): _____

Date: _____ Time: _____

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT

Patient Name: _____ DOB: _____