PRIVATE AND CONFIDENTIAL

FUTURE GENETICS®

Sleep Scale

Name: _____ Age: _____ Gender:

Surgery: _____ Dr: _____

Date: _____

PLEASE ANSWER THE FOLLOWING **12 QUESTIONS** OF THIS **HEALTH SURVEY** COMPLETELY, HONESTLY AND WITHOUT INTERRUPTIONS.

1. How long did it usually take for you to **fall asleep** during the past **4 weeks?**

2. On the average, how many hours did you sleep **each night** during the **past 4 weeks**?

How often during the past 4 weeks did you…

3. Feel that your sleep was not quiet (moving restlessly, feeling tense, speaking, etc., while sleeping)?

4. Get enough sleep to feel rested upon waking in the morning?

5. Awaken short of breath or with a headache?

6. Feel drowsy or sleepy during the day?

7. Have trouble falling asleep?

8. Awaken during your sleep time and have trouble falling asleep again?

9. Have trouble staying awake during the day?

10. Snore during your sleep?

11. Take naps (5 minutes or longer) during the day?

12. Get the amount of sleep you needed?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

STAFF USE ONLY

Participants NHS Number:

Researchers Name:

NHS Site Number:

NHS Site Name:

Postcode: