This Philips Questionnaire is specifically developed to calculate the likeness than you suffer from sleep apnea. It consists of 3 sections with in total 23 questions about your personal characteristics, your sleep behavior and your welfare.

It is imperative that you answer all questions in this questionnaire, even if some questions seem to be similar. All your answers are valuable in predicting your sleep apnea risk!
SECTION I PERSONAL DATA

Please fill out the following requests for personal information as accurately as possible.

1. What is your age?
   _____years

2. What gender are you?
   a. male
   b. female

3. How much do you weight?
   _____kg

4. How tall are you?
   _____cm

5. What is the circumference of your neck in cm?
   _____cm

6. Do you suffer from high blood pressure?
   a. yes
   b. no
   c. don’t know

Please continue on the next page
SECTION II SLEEP DATA

*Please select the most appropriate answer for each question and circle it.*

1. Do you snore?
   a. yes
   b. no
   c. don't know

*If you snore (the answer on the above question is "yes"):

2. When you snore, is this:
   a. slightly louder than breathing
   b. the same volume as talking
   c. louder than talking
   d. very loud --- can be heard in adjacent rooms

3. How often do you snore?
   a. almost every day
   b. 3---4 times a week
   c. 1---2 times a week
   d. 1---2 times a month
   e. never or very rarely

4. Has your snoring ever disturbed other people?
   a. yes
   b. no
   c. don't know

*Please continue on the next page*
5. How often do you get up feeling that you are tired and have not had enough sleep?
   a. almost every day
   b. 3---4 times a week
   c. 1---2 times a week
   d. 1---2 times a month
   e. never or very rarely

6. When you are awake, do you often feel tired, not rested or not alert?
   a. almost every day
   b. 3---4 times a week
   c. 1---2 times a week
   d. 1---2 times a month
   e. never or very rarely

7. Do you snore loudly (louder than you talk and loud enough to be heard through closed doors)?
   a. yes
   b. no

8. Do you often feel tired, not rested or sleepy during the day?
   a. yes
   b. no

9. Has anyone ever observed you stop breathing when you are asleep?
   a. yes
   b. no

Please continue on the next page
SECTION III SLEEP DATA

Please circle the appropriate answer in the items below to indicate you estimate of any sleep difficulty, provided that it occurred at least three times per week during the last month.

1. Sleep induction (time it takes you to fall asleep after turning off the lights)
   a. no problem
   b. slightly delayed
   c. markedly delayed
   d. very delayed or did not sleep at all

2. Awakenings during the night
   a. no problem
   b. minor problem
   c. considerable problem
   d. serious problem or did not sleep at all

3. Final awakening earlier than desired
   a. not earlier
   b. a little earlier
   c. markedly earlier
   d. much earlier or did not sleep at all

4. Total sleep duration
   a. sufficient
   b. slightly insufficient
   c. markedly insufficient
   d. very insufficient or did not sleep at all

Please continue on the next page
5. Overall quality of sleep (no matter how long you slept)
   a. satisfactory
   b. slightly unsatisfactory
   c. markedly unsatisfactory
   d. very unsatisfactory or did not sleep at all

6. Sense of well-being during the day
   a. normal
   b. slightly decreased
   c. markedly decreased
   d. very decreased

7. Functioning (physical and mental) during the day
   a. normal
   b. slightly decreased
   c. markedly decreased
   d. very decreased

8. Sleepiness during the day
   a. none
   b. mild
   c. considerable
   d. intense

Thank you for your cooperation!