***(Reduced) Functional Outcomes of Sleep Questionnaire (FOSQ-10)***

**Ql.** Do you have difficulty concentrating on the things you do because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

**Q2.** Do you generally have difficulty remembering things because you are sleepy or tired?

1. Yes, extreme
2. Yes, moderate
3. Yes, a little 4. No

**Q3.** Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?

* 1. Yes, extreme
	2. Yes, moderate
	3. Yes, a little 4. No

**Q4.** Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?

* + 1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

**Q5.** Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

**Q6.** Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?

1. Yes, extreme
2. Yes, moderate
3. Yes, a little 4. No

**Q7.** Do you have difficulty watching a movie or video because you become sleepy or tired?

* 1. Yes, extreme
	2. Yes, moderate
	3. Yes, a little 4. No

**Q8.** Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?

* + 1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

**Q9,** Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

**Q10.** Has your mood been affected because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

**Total Score:** \_\_\_\_\_\_\_\_\_\_

Patient Name: Last, First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_