Intermountain®
Dixie Regional
Sleep Disorders Center

ACCREDITED MEMBER CENTER

Dixie Regional Sleep Disorders Center

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Functional Outcomes of Sleep Questionnaire (FOSQ)

Patient Name: **Date of Visit:**

Date of Birth:

Directions: Please put a (✓) in the box for your answer to each question. Select only **one** answer for each question. Please try to be a accurate as possible. All information will be kept confidential.

	(0) I don't do this activity for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
1 Do you have difficulty concentrating on the things you do because you are sleepy or tired?		❒	❒	❒	❒
2 Do you generally have difficulty remembering things, because you are sleepy or tired?		❒	❒	❒	❒
3 Do you have difficulty operating a motor vehicle for **short** distances (less than 100 miles) because you become sleepy or tired?	❒	❒	❒	❒	❒
4 Do you have difficulty operating a motor vehicle for **long** distances (greater than 100 miles) because you become sleepy or tired?	❒	❒	❒	❒	❒
5 Do you have difficulty visiting with your family or friends in **their** home because you become sleepy or tired?	❒	❒	❒	❒	❒
6 Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?	❒	❒	❒	❒	
7 Do you have difficulty watching a movie or videotape because you become sleepy or tired?	❒	❒	❒	❒	❒
8 Do you have difficulty being as active as you want to be in the **evening** because you are sleepy or tired?		❒	❒	❒	❒
9 Do you have difficulty being as active as you want to be in the **morning** because you are sleepy or tired?		❒	❒	❒	❒
10 Has your desire for intimacy or sex been affected because you are sleepy or tired?	❒	❒	❒	❒	❒

Thank you for completing this questionnaire.