Sleep Questionnaire

Completion of this form is important for the possible diagnosis of sleep related breathing disorders, such as snoring and/or obstructive sleep apnea. These conditions can disrupt normal sleep patterns, reduce normal blood oxygen levels, contribute to high blood pressure, heart disease, stroke, diabetes, obesity, memory and learning problems, and depression. Since these disorders are of an oral nature, it is our practice 's commitment to your health and wellbeing that requires us to present you with this brief questionnaire.

Please check only one box per question:

☐ yes ☐ no 1. Do you snore during sleep?

☐ yes ☐ no 2. Are you **tired** during the day?

☐ yes ☐ no 3. Do you ever awaken **choking, gasping, or coughing**?

☐ yes ☐ no 4. Do you experience morning or daytime **headaches?**

☐ yes ☐ no 5. Are you **overweight**?

☐ yes ☐ no 6. Do you **awaken repeatedly** during the night?

☐ yes ☐ no 7. Have you ever been treated for **diabetes**?

☐ yes ☐ no 8. Have you ever been treated for any **heart issues**?

☐ yes ☐ no 9. Are you being treated for **high blood pressure**?

☐ yes ☐ no 10. Have you ever had a sleep study?

Please check only one:

☐ After reviewing this questionnaire with my doctor, I am **requesting** further information regarding sleep apnea.

☐ After reviewing this questionnaire with my doctor, I **decline** further information regarding sleep apnea.

Name:_____Signature: _____ Date: __/___/___

For Office Use Only: **Initials & Date:**

☐ I have reviewed the responses to this questionnaire with the patient & doctor. _____

☐ I have documented the patient chart note on the computer . _____