Dreamhaven dental sleep medicine

Questionnaire for Sleep Apnea and/or Snoring

(use back if more space is needed)

Name: _____ Date: _____

1. How long have you been aware of your snoring? _____
2. Has it caused problems for relatives or friends? _____
3. Have you been told your breathing stops while asleep? _____
4. Have you been told you move around a lot while you sleep? _____
5. About how many times per night do you wake up? _____
6. Do you have difficulty falling asleep at night? _____
7. How many hours of sleep per night do you get? _____
8. Do you most often wake up feeling refreshed? _____
9. Do you often wake up with a headache? _____
10. Will a small amount of alcohol give you a hangover? _____
11. Do you feel sleepy during the day? __ frequently __ occasionally __ seldom __never
12. What other doctors have you seen about your snoring or sleep apnea?

_____

_____

13. Have you had a sleep lab study? ___ Yes ___No
14. Do you have difficulty breathing through your nose? ___ Yes ___ No
15. Have you gained weight recently? ___ Yes ___ No
    About how much? _____
16. Present body weight: _____ Height: _____ft. _____ inches
17. What professional advice or treatment have you received about your snoring or sleep apnea?

_____

_____

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_____

Signature: _____ Date: _____