NRH ORTHODONTICS

Where beautiful smiles are made

Name: _____ DOB: _____

Adult Sleep and Breathing Questionnaire

Have you ever had a sleep test administered?	Y	N
If yes, when did you have your last sleep test? _____		
Have you been diagnosed with Sleep Apnea?	Y	N
Do you currently use a CPAP or Sleep Appliance?	Y	N
How often do you get out of bed to use the restroom during the night? _____		
Do you usually wake feeling tired and unrested?	Y	N
Do you habitually snore?	Y	N
Have you been diagnosed with Hypertension/High Blood Pressure?	Y	N
Do you often suffer from waking headaches?	Y	N
Do you regularly experience daytime drowsiness or fatigue?	Y	N
Do you have blocked nasal passages?	Y	N
Has anyone observed you stop breathing during your sleep?	Y	N
Do you ever wake up choking or gasping?	Y	N
Do you grind your teeth while sleeping?	Y	N