ALLAN K. BERNSTEIN, D.D.S.

Questionnaire for Sleep Apnea and/or Snoring

Name: _____ **Date:** _____

- How long have you been aware of your snoring? _____
- Has it caused problems for relatives or friends? _____
- Have you been told your breathing stops while asleep? _____
- About how many times per night do you wake up? _____
- Do you have difficulty falling asleep at night? _____
- How many hours of sleep do you get per night? _____
- Do you most often wake up feeling refreshed? _____
- Do you often wake up with a headache? _____
- Will a small amount of alcohol give you a hangover? _____
- Do you feel sleepy during the day?
- _____ frequently _____ occasionally _____ seldom _____ never
- What other doctors have you seen about your snoring or sleep apnea? _____

- Have you had a sleep lab study? _____ yes _____ no
- Do you have difficulty breathing through your nose? _____ yes _____ no
- Have you gained weight recently? ___ yes ___ no About how much? _____
- Present body weight: _____ Height: _____ feet _____ inches
- What professional advice or treatment have you received regarding your snoring or sleep apnea. (i.e. CPAP)? _____

- Please describe any method of positioning your jaw that will improve breathing:

- Have you had any serious trouble associated with any previous dental treatment? ____

- What part of the body do you usually sleep on? *Stomach* *Side* *Back*

_____ _____

Patient Signature **Date**