Dental Sleep Questionnaire

Patient Information:

Name: _____ Date: _____

1.	Do you snore loudly or have been told that you snore?	Yes	No
2.	Do you ever awaken with a sensation of gasping or choking?	Yes	No
3.	Has anyone ever noticed that you stop breathing during your sleep?	Yes	No
4.	Do you often wake up with a dry mouth?	Yes	No
5.	Do you find your sleep to be non-refreshing?	Yes	No
6.	Do you often feel tired, fatigued, or sleepy during daytime?	Yes	No
7.	Do you ever fall asleep or nod off in situations where you did not intend to?	Yes	No
8.	Do you have (or are being treated for) high blood pressure and/or diabetes?	Yes	No

If you answered YES to 3 or more questions, you may benefit from a Home Sleep Test to evaluate the presence of Obstructive Sleep Apnea. The doctor or hygienist will do a more extensive evaluation at your dental exam.