SNORING AND OBSTRUCTIVE SLEEP APNEA (OSA) SCREENING QUESTIONNAIRE

Name: _____ Birthdate ____/____/____ Sex _____ Ht _____ Wt _____

Phone: home _____/_____ _____ wk _____/_____ _____ Cell _____/_____ _____

Street _____ City _____ State _____ Zip_____

This questionnaire was designed to provide important facts regarding the history of your sleep condition. To assist in determining the source of any problem, please take your time and answer each question completely and as honestly as possible. Please sign each page.

Please answer the following questions and rate the chief complaints you are seeking treatment for with #1 being the most important.

During usual sleep, have you noticed or been told you do the following:

A) Snore loudly which affect the sleep of others	Y ❑	N ❑	Rating_____
B) Choke, struggle for breath or stop breathing	Y ❑	N ❑	Rating_____
C) Wake because of breathing problems	Y ❑	N ❑	Rating_____
D) Toss and turn frequently	Y ❑	N ❑	Rating_____
E) Kick or jerk legs repeatedly	Y ❑	N ❑	Rating_____
F) Grind your teeth	Y ❑	N ❑	Rating_____

When you wake up after your usual sleep, do you experience the following:

A) Headache	Y ❑	N ❑	Rating_____
B) Dry mouth	Y ❑	N ❑	Rating_____
C) Feel tired or un-rested	Y ❑	N ❑	Rating_____

During the time you are usually awake (daytime and evening), do you experience:

A) Jaw pain	Y ❑	N ❑	Rating_____
B) Facial pain	Y ❑	N ❑	Rating_____
C) Jaw clicking	Y ❑	N ❑	Rating_____
D) Memory loss	Y ❑	N ❑	Rating_____
E) Difficulty concentrating	Y ❑	N ❑	Rating_____

During the time you are usually awake (daytime and evening), do you become irresistably sleepy or fall asleep in the following situations:

A) Sitting talking to someone	Y ❑	N ❑	Rating_____
B) After a meal (when you've had no alcohol)	Y ❑	N ❑	Rating_____
C) Reading or watching TV	Y ❑	N ❑	Rating_____
D) At work	Y ❑	N ❑	Rating_____
E) While a passenger in a vehicle	Y ❑	N ❑	Rating_____
F) While driving a vehicle	Y ❑	N ❑	Rating_____

If you answered 'YES' to at least 4 of the questions you very likely have some level of Obstructive Sleep Apnea, which can contribute to many serious medical conditions.

Should you desire to discuss treatment options please either email or mail this form to Dr. Don. A quick telephone call just might be your first step to attaining a better 'quality of life.'

Gregory C. Don, D.D.S.
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Patient Signature _____ Date _____