dental partners of Vero Beach

Comprehensive Dentistry
Airway Orthodontics
& Sleep Solutions
For Patients of All Ages

Adult Sleep Disordered Breathing Questionnaire

Patient Name: _____ Height: _____
Primary Phone: _____ Weight: _____
Date of Birth: _____ Gender: _____
Age: _____ General Practitioner: _____
Do you feel you may have sleep apnea? ❑ Yes ❑ No
Do you smoke? ❑ Yes ❑ No

Instructions: Use the scale below to choose the most appropriate response for each situation. Please Check Off

Situation	**Chance of Dozing**			
	Never	**Slight**	**Moderate**	**High**
Sitting and reading	❑	❑	❑	❑
Watching TV	❑	❑	❑	❑
Sitting inactive in a public place	❑	❑	❑	❑
As a passenger in a car for an hour	❑	❑	❑	❑
Laying down in afternoon	❑	❑	❑	❑
Sitting and talking to someone	❑	❑	❑	❑
Sitting quietly after lunch (no alcohol)	❑	❑	❑	❑
In a car and stopped for a few minutes	❑	❑	❑	❑

Other: _____

Do you snore? ❑ Yes ❑ No
If Yes, Complete the following section, If No, proceed to next section
If you snore, your snoring is
❑ As loud as talking ❑ Can be heard in adjacent rooms
❑ Louder than talking ❑ Slightly louder than breathing

Has your snoring bothered other people ❑ Yes ❑ No ❑ Don't Know

	Nearly everyday	1-2 times a week	3-4 times a week	1-2 times a month	Never or nearly never
How often do you snore?	❑	❑	❑	❑	❑
Has anyone noticed that you stopped breathing while sleeping?	❑	❑	❑	❑	❑
Have you ever fallen asleep or nodded off driving a vehicle?	❑	❑	❑	❑	❑
Has anyone noticed that you quit breathing in your sleep?	❑	❑	❑	❑	❑
How often do you feel fatigued or tired after your sleep?	❑	❑	❑	❑	❑
During your wake time, do you feel tired, fatigued, or not up to par?	❑	❑	❑	❑	❑

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Please Check All That Apply

Sleep Symptoms

Frequent bathroom visits nightly	❑
Gasping, choking or snorting during sleep	❑
Restless legs	❑
Limbs jerking/twitching at night	❑
Moring headaches	❑
Insomnia	❑
Restless sleep	❑
Memory loss	❑
Waking up paralyzed	❑
Teeth grinding/clenching	❑
Audible or visual hallucinations around sleep	❑
Family history of sleep apnea	❑

Please Check All That Apply

Health Issues

Heart disease	❑
Stroke	❑
COPD	❑
Other lung disease	❑
Gastric Acid Reflux	❑
Chronic pain	❑
Fibromyalgia	❑
Diabetes	❑
High blood pressure	❑
Oxygen use	❑
Pacemaker	❑
Depression	❑
Erectile Dysfunction	❑

Alcohol Consumption, Please specify: ❑ Daily ❑ Weekly ❑ 3-5 times a week ❑ Weekends ❑ Special Occasions

SURGERIES

Previous Oral/Nasal Surgery ❑ YES ❑ NO If Yes Please Explain

Doctors Name _____ Date of Procedure:_____

Previous Tonsil and Adenoids Removed ❑ YES ❑ NO If Yes Please Explain

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Doctors Name _____ Date of Procedure:_____