PATIENT INFORMATION – Sleep Study/Questionnaire Date: _____

Patient Name: _____ Age: _____ Sex: _____

Do you feel tired or easily fatigued during the day?	YES / NO	
Do you snore?	YES / NO	
Do you wake up with a dry mouth or sore throat?	YES / NO	
Do you feel you have restless or fitful sleep?	YES / NO	
Do you experience choking, snorting or gasping during sleep?	YES / NO	
Do you awaken in the morning feeling tired/groggy?	YES / NO	
Do you have occasional feeling of "confusion" or "spaced out"?	YES / NO	
Do you suffer from low sex drive or getting up frequently at night?	YES / NO	
Do you experience forgetfulness and difficulty concentrating?	YES / NO	
Do you have morning or frequent headaches?	YES / NO	
Do you get headaches/Migraines? How many headaches (H) and Migraines (M) _____ (H) /_____ (M) each week? _____ (H) / _____ (M) each month?	YES / NO	
Do you clench your teeth at night or during the day?	YES / NO	
When you wake up, does your jaw joint/muscle feel tight or sore?	YES / NO	
Are you aware of any of the following: • Popping/Clicking • Grinding • Noise in Jaw Joints	YES / NO	
Have you noticed a change in your bite?	YES / NO	
Do you fall asleep sitting, reading, watching TV or driving?	YES / NO	
Have you been in a motor vehicle accident in the past year?	YES / NO	
Have you ever had any sports injuries?	YES / NO	
Do you have any of the following? (please check all that apply) o High Blood Pressure o Diabetes o Thyroid Disease o Hormone Disorders o Weight Gain o Irregular Heart Beat o Hypertension o Anxiety/Depression	YES / NO	