Sleep Apnea & Snoring
TMJ Disorders
Head & Facial Pain

SLEEP SCREENING QUESTIONNAIRE

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

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss ☐ Mrs. ☐ Dr. Today's Date: _____

NAME: _____ First _____ Middle Initial _____ Last _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____ ☐ MALE ☐ FEMALE

CELL PHONE: _____ E-MAIL ADDRESS: _____

SOCIAL SECURITY NUMBER: ___-___-___ DATE OF BIRTH: ___/___/___ AGE: _____

RESPONSIBLE PARTY: _____ PHONE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYER: _____ ADDRESS: _____

REFERRED BY: _____ ADDRESS: _____

FAMILY PHYSICIAN: _____ ADDRESS: _____

FAMILY DENTIST: _____ ADDRESS: _____

PRIMARY INSURANCE: _____	SECONDARY INSURANCE: _____
POLICY HOLDER: _____	POLICY HOLDER: _____
POLICY HOLDER DOB: _____	POLICY HOLDER DOB: _____

☐ Please check here if you are pregnant or think you might be, and let our office know.

WHAT ARE THE UNDER 4 COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please number the complaints in order of importance or bothersome to you.

_____ Frequent heavy snoring
_____ Waking up with a sore throat
_____ Dry mouth
_____ CPAP intolerance
_____ Significant daytime drowsiness
_____ Difficulty falling asleep
_____ Gasping when waking up
_____ Nightmares (waking up)
_____ Waking in sweat at night
_____ I have been told that "I stop breathing" when sleeping
_____ Feeling unrelaxed in the morning
_____ Morning headaches
_____ Morning headaches
_____ Morning headaches
_____ Nocturnal teeth grinding
_____ Ear pain
_____ Facial pain
_____ Ear clicking

Other: _____

Patient Name: _____ Date: _____

Office Use Only
Ht:
Wt:
BMI:
Neck:
Tongue: