Adult Sleep & Breathing Questionnaire

Patient Information

Patient First Name: _____

Patient Last Name: _____

Preferred Name: _____

Date of Birth _____

Please indicate if you experience or have experienced any of the symptoms below by using this scale to measure severity of these symptoms:

Snoring During Sleep: _____

Grinding during sleep _____

Wakes up at night: _____

Mouth Breathing: _____

Wetting/History of wetting the bed: _____

Headaches/TMJ Pain _____

Trouble focusing during the day: _____

Daytime Drowsiness/ Fatigue/ Irritability _____

Seasonal Allergies _____

Infection: Sinus/Throat/Ear _____

Anxiety/Depression _____

ADD/ADHD _____

Please indicate if you have ever been diagnosed with any of the following:

Conditon	Yes	No	IF YES PLEASE STATE THE YEAR OF DIAGNOSIS
High Blood Pressure	☐	☐	
Diabetes	☐	☐	
Sleep Apnea	☐	☐	
Cardiovascular Disease	☐	☐	

By Signing you acknowledge all the information above is correct:

Sign