DENTAL SLEEP APNEA, SNORING
AND TMJ TREATMENT CENTER

Dr. Charles Schneider

Name: _____ Date: _____

Please number your chief complaints starting with the number one being the most important.

_____ Frequent heavy snoring
_____ Frequent heavy snoring, which affects the sleep of others
_____ Significant daytime drowsiness
_____ I have been told, “I stop breathing” when sleeping
_____ Difficulty falling asleep
_____ Gasping when waking up
_____ Nighttime choking spells
_____ Feeling unrefreshed in the morning
_____ Morning hoarseness
_____ Swelling in ankles or feet
_____ Nocturnal teeth grinding
_____ Jaw Pain
_____ Facial Pain
_____ Jaw Clicking

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