DENTAL SLEEP APNEA, SNORING
AND TMJ TREATMENT CENTER

Dr. Charles Schneider

Questionnaire for Sleep Apnea and/or Snoring

Name: _____ Date: _____

How long have you been aware of your snoring? _____

Has it caused problems for relatives or friends? _____

Have you been told your breathing stops while asleep? _____

Have you been told you move around a lot while you sleep? _____

About how many times per night do you wake up? _____

Do you have any difficulty falling asleep at night? _____

How many hours of sleep per night do you get? _____

Do you most often wake up feeling refreshed? _____

Do you often wake up with a headache? _____

Will a small amount of alcohol give you a hangover? _____

Do you feel sleepy during the day? _____

What other doctors have you seen about snoring or Sleep Apnea? _____

Have you had a sleep study done? _____

Do you have difficulty breathing through your nose? _____

Have you gained weight recently? _____

How much? _____

Present Body Weight: _____ Height _____

What professional advice or treatment have you received about snoring or sleep apnea?

_____

_____

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_____

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