

# Sleep Questionnaire

Certain sleep disorders may be treated in the dental office. Please check if you currently have or have had any of the following:

- \_\_\_\_\_ Has anyone said you snore loudly?
- \_\_\_\_\_ Sleep walk
- \_\_\_\_\_ Snore in all positions
- \_\_\_\_\_ Sleep talk
- \_\_\_\_\_ Has anyone said you stop breathing
- \_\_\_\_\_ Wake up gasping for breath
- \_\_\_\_\_ Wake up coughing or choking
- \_\_\_\_\_ Grind your teeth in your sleep
- \_\_\_\_\_ Wake up with headaches
- \_\_\_\_\_ Wake up with a sore throat
- \_\_\_\_\_ Difficulty initiating sleep at night
- \_\_\_\_\_ Wake up with chest tightness
- \_\_\_\_\_ Difficulty maintaining sleep at night
- \_\_\_\_\_ Were you excessively sleepy as a child, teenager, or young adult?

## SLEEP SCHEDULE

Weekday:

Weekend:

What time do you go to bed?

\_\_\_\_\_

\_\_\_\_\_

What time do you wake up?

\_\_\_\_\_

\_\_\_\_\_

Average amount of sleep per night: \_\_\_\_\_ Hours

\_\_\_\_\_

Do you have a rotating schedule or night shift work? \_\_\_\_\_

How long does it take you to go to sleep?

\_\_\_\_\_

How do you feel when you wake up?

\_\_\_\_\_