SLEEP SCREENING QUESTIONNAIRE

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

Patient Information

TODAY'S DATE: _____

☐ MR. ☐ MS ☐ MISS ☐ MRS. ☐ DR. NAME: _____
FIRST MIDDLE INITIAL LAST

AGE: _____ DATE OF BIRTH: _____ ☐ Male ☐ Female

ADDRESS: _____

CITY/STATE/ZIP: _____

HOW LONG AT CURRENT ADDRESS? _____ (IF LESS THAN THREE YEARS, PLEASE GIVE PREVIOUS ADDRESS)

PREVIOUS ADDRESS: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____

HOME PHONE: _____ BUSINESS PHONE: _____

RESPONSIBLE PARTY: _____

FAMILY PHYSICIAN _____

ADDRESS _____

INSURANCE

MEMBER NUMBER _____

GROUP NUMBER _____

PLAN NUMBER _____

NAME OF PRIMARY CARE PHYSICIAN _____

HEIGHT: _____ feet _____ inches

WEIGHT: _____ pounds

REFERRED BY: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please <u>number</u> the complaints with #1 being the most important.

___ Frequent heavy snoring
___ which affects the sleep of others
___ Significant daytime drowsiness
___ I have been told that "I stop breathing" when sleeping.
___ Difficulty falling asleep
___ Gasping when waking up
___ Nighttime choking spells
___ Feeling unrefreshed in the morning
___ Morning hoarseness
___ Morning headaches
___ Swelling in ankles or feet
___ Nocturnal teeth grinding
___ Jaw pain
___ Facial pain
___ Jaw clicking

Other: _____ _____

Patient Signature _____ Date _____

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