ADULT SLEEP/BREATHING QUESTIONNAIRE

Name ______ Gender M F Date of Birth / / Weight lbs. Height ' "

Address, City, State ______ Zip ______

Cell Phone ______ Alt. Phone ______ Email ______

Patient Sleepiness Scale Risk Factors: Please check all that apply:	pts	Additional Comments Below:
1. I have been told that I stop breathing while asleep.	8	
2. I have fallen asleep or nodded off while driving.	6	
3. I've woken up with shortness of breath/gasping or my heart racing.	6	
4. I feel excessively sleepy or fatigued during the day.	4	
5. I snore or have been told that I snore.	4	
6. I have had weight gain and found it difficult to lose.	4	
7. I have been diagnosed with high blood pressure.	4	
8. It takes me less than 10 minutes to fall asleep.	4	
9. I wake up more than 1 time per night.	4	
10. I wake up with headaches.	4	
11. I have been prescribed a CPAP.	12	

Total points from above: ____________ Check your risk level score: Low: 0-7 Moderate: 8-11 High: 12-15 Severe:16+

Patient Health History (Signs and Symptoms): Circle all that apply	
Snoring	Diabetes
Depression/Anxiety	History of Stroke/Heart Disease
Unrefreshed Upon Waking	Acid Reflux/GERD
Witnessed Choking/Gasping for breath	Memory Loss
Irritability/Moodiness	Family History Of Sleep Apnea
Sinus/Allergy Issues	Deviated Septum
Grind Teeth	Inability to breath through nose
Asthma	Wakes Up With Dry Mouth
TMJ Pain/Popping/Click	Wears CPAP

*All of the above are associated with or can be caused by improper breathing and/or sleep

Physical Characteristics

BMI > 30 Tongue Tie

Narrow Upper Arch

Visual Airway Obstruction

Large/Scalloped Tongue

Neck size: Male >16"; Female >15"

______ Inches
Neck Size

______
Blood Pressure

______ BPM
Heart Rate

______
BMI

______
Patient Signature Date