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 MRS DR
MS MISS NAME: _____

AGE: _____ BIRTH DATE: _____ 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: _____ WORK PHONE:_____

CELL PHONE: _____ EMAIL: _____

RESPONSIBLE PARTY: _____

FAMILY PHYSICIAN:

_____

ADDRESS: _____

FAMILY DENTIST:

_____

ADDRESS: _____

PLEASE LIST OTHER HEALTH CARE PRACTICIONERS SEEN IN THE LAST 9 MONTHS: _____

_____

INSURANCE_____
MENMBER NUMBER: _____ HEIGHT _____ feet _____ inches
GROUP NUMBER: _____
PLAN NUMBER: _____ WEIGHT _____ pounds
NAME OF PRIMARY
CARE PHYSICIAN: _____

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
__ 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: _____