

Advanced Patient Sleep Screening Form v. 1.0

Patient Information

Last Name: _____ First Name: _____

DOB: / / Sex: M / F Height: Weight:

Blood Pressure: _____

Is patient on hypertension medication? Yes / No

Patient Questions & Symptoms

When you wake up after typical sleep, how often do you experience the following:

	Daily	Often	Infreq	Never
A. Headache	_____	_____	_____	_____
B. Dry mouth	_____	_____	_____	_____
C. Tired and not rested	_____	_____	_____	_____

Do you have trouble breathing through your nose?:

	Daily	Often	Infreq	Never
A. During the day	_____	_____	_____	_____
B. Nighttime in bed	_____	_____	_____	_____

Do you consume alcoholic beverages or take sedatives?:

	Daily	Often	Infreq	Never
A. During the day	_____	_____	_____	_____
B. Nighttime in bed	_____	_____	_____	_____

Do you take medications for:

Heart Condition	Y / N	Respiratory Condition	Y / N
Thyroid Condition	Y / N	Weight	Y / N

1. How long have you been aware of your snoring? _____
2. Has it caused problems for relatives or friends? Y / N
3. Have you been told your breathing stops while asleep? Y / N
4. Have you been told you move around a lot while asleep? Y / N
5. What position do you sleep in? Side____ Back____ Stomach____
6. About how many time per night do you wake up? _____
7. Do you have any difficulty falling asleep at night? Y / N
8. How many hours of sleep do you get per night on average? _____
9. Do you normally wake up feeling refreshed? Y / N
10. Do you often wake up with a headache? Y / N

- 11. Does a small amount of alcohol give you a headache? Y / N
- 12. Do you suffer from memory loss? Y / N
- 13. Do you experience depression? Y / N
- 14. Do you have pain or clicking/popping in your jaw? Y / N

If yes, please describe:
