Alice Lam DDS

SLEEP QUESTIONNAIRE

Your Name: _____ Age: _____ Date of Birth: _____

Please check the following questions that apply to you:

Do you snore? ☐ Mild ☐ Moderate ☐ Severe? How many years? _____

Do you snore: ☐ on your side ☐ on your back?

Usual position: ☐back ☐ side ☐ stomach

☐ You fall asleep when reading, watching TV or other passive activities.

☐ You fight sleepiness on the job or when driving.

☐ You most often wake up with headaches.

☐ You wake up choking or gasping for air.

☐ You most often wake up feeling tired, fatigued and unrefreshed.

☐ You take naps during the day. If so, for how long? _____

☐ You have trouble *falling* asleep. On average, how long does it take to fall asleep? _____

☐ You have trouble *staying* asleep throughout the night. Number of times you wake up? __

Lengths of time getting back to sleep after you wake up? _____

☐ You have restless or "creepy, crawly" leg feelings.

☐ You experience unusual behaviors just before, during or after sleep.

☐ You wake up feeling *paralyzed*.

☐ You experience a sudden loss of strength in your arms/ legs during the day.

☐ You feel unhappy or discouraged about your sleep.

☐ Your sleep problem affects your family life; work performance.

☐ Intake caffeinated beverages each day. How many? _____

☐ You think you get enough sleep at night. Number of hours per night_____

Does your bed partner complain of:

☐ Your loud snoring.

☐ Your partner sometimes sleeps in another room at night because of your snoring.

☐ Your twitching legs, kicking or excessive moving at night.

☐ Long breathing pauses during your sleep.

Do you have or ever had the following:

☐ Jaw popping, clicking or grinding.

☐ Your jaw has locked or gotten stuck.

☐ Been diagnosed with TMJ.

☐ Been told you grind your teeth at night (brux).

☐ Ever had a mouth guard made by a Dentist.

☐ Pain with chewing.

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Rank how likely it would be for you to become drowsy during the day in the following situations:

0= Would never doze
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Epworth Sleepiness Scale

Situation	Chance of dozing
Sitting & Reading	
Watching TV	
Sitting inactive in a public place (i.e. theater)	
As a car passenger for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, stopped for a few minutes in traffic	
Total score:	

My sleep problems are: _____

_____

Sleep Medications taken in the last year: (includes nonprescription)

_____

Do you have any of the following?

- ☐ High Blood Pressure
- ☐ Heart problems
- ☐ Type 2 Diabetes
- ☐ Acid Reflux or heartburn If so: ☐ Morning ☐ Night
- ☐ Feel as though you are over your healthy weight.

What is your Ht: _____ Wt: _____

Have you ever had a sleep study? ☐Yes ☐ No

If Yes, then please have the sleep lab fax results to: 281.531.5761. Thank you.

Patient Signature: _____ Date: _____