SHERRY DENTAL PC
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SLEEP QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

	YES	NO
DO YOU SNORE?	_____	_____
IS SNORING A PROBLEM FOR YOU?	_____	_____
DOES YOUR SIGNIFICANT OTHER SNORE?	_____	_____
IS SNORING A PROBLEM FOR YOUR RELATIONSHIP?	_____	_____
HAVE YOU BEEN TOLD YOU STOP BREATHING WHEN YOU SLEEP?	_____	_____
HAVE YOU EVER HAD A SLEEP TEST?	_____	_____
ARE YOU MORE THAN 30LBS OVER WEIGHT	_____	_____
ARE YOU HAVING TROUBLE LOSING WEIGHT?	_____	_____
DO YOU WAKE UP EXHAUSTED IN THE MORNING?	_____	_____
DO YOU EXPERIENCE DAYTIME SLEEPINESS?	_____	_____