# Adult Sleep and Breathing Questionnaire

Date: ____________________

Patient's Name: ________________________________________________________

Patient's Date of Birth: ____________________________ Age: ____________

Male: ______ Female: ______

Have you ever had a sleep test administered? **Yes** **No**

**If yes**, when did you have your last sleep test? _________________________

Have you been diagnosed with Sleep Apnea? **Yes** **No**

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? **Yes** **No**

**If yes,** are you happy with your CPAP or Sleep Appliance? **Yes** **No**

**If you are not happy**, why? ______________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

How often do you get out of bed to use the restroom during the night? _______________________

| | Yes | No |
|---|---|---|
| Do you usually wake up feeling tired and unrested? | ☐ | ☐ |
| Do you habitually snore? | ☐ | ☐ |
| Have you been diagnosed with Hypertension/High Blood Pressure? | ☐ | ☐ |
| Do you suffer from waking headaches? | ☐ | ☐ |
| Do you regularly experience daytime drowsiness or fatigue? | ☐ | ☐ |
| Do you have blocked nasal passages? | ☐ | ☐ |
| Has anyone observed you stop breathing during your sleep? | ☐ | ☐ |
| Do you ever wake up choking and/or gasping? | ☐ | ☐ |
| Do you clench/grind your teeth? | ☐ | ☐ |
| Do you have acid reflux/heartburn? | ☐ | ☐ |
| Do you take any medication to help you sleep? | ☐ | ☐ |
| Do you have a history of anxiety and/or depression? | ☐ | ☐ |