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 potential problem, please take your time and answer each question as completely and honestly as possible.

Do you experience any of the following?

Do you experience any of the following?	Yes	No
Frequent heavy snoring?		
Significant daytime drowsiness?		
I have been told that "I stop breathing" when sleeping.		
Difficulty falling asleep?		
Feeling unrefreshed in the morning?		
Morning headaches?		
Forgetfulness or memory problems?		
Irritable bowel syndrome?		
Nasal congestion?		
Depression?		
Anxiety?		
Gastric reflux?		
Restless leg syndrome?		
Dry mouth in the morning?		
Jaw pain?		
Teeth grinding?		

Patient Signature_____ Date _____