Sleep & Breathing

Name_____DOB_____

M/F Height_____Weight_____BMI_____

Occupation_____

1. Do you breathe through your mouth? Yes_____No_____
2. Do you have dry mouth or non productive cough? Yes_____No_____
3. Do you have any nasal allergies? Yes_____No_____
4. Do you snore while sleeping? Yes_____No_____
5. Do you stop or pause breathing while sleeping? Yes_____No_____
6. If yes, have you had a sleep study done? Yes_____No_____
7. Do you wear a c-pap? Yes_____NO_____
8. Do you wake up fatigued? Yes_____No_____
9. Do you have morning tension or migraine headache? Yes_____No_____

If yes, how often?_____

10. Do you get tired easily or fall asleep during the day? Yes_____No_____
11. Do you clench or grind your teeth at night? Yes_____No_____
12. Do you have facial pain? Yes_____No_____

If yes, where ?_____

13. Do you drink alcohol or take sleep aids at night? Yes_____No_____
14. Do you suffer from hypertension? Yes_____No_____

    Do you take medication for hypertension? Yes_____No_____

15. Have you been diagnosed with any of the following?

    Chronic Fatigue Syndrome_____ Irritable Bowel Syndrome_____

    Fibromyalgia_____TMJ_____ Sleep Apnea_____