Dental Sleep Questionnaire

Name:______________________________ Date:_______________

1. Have you ever had a sleep study done? Yes [ ] No [ ]
2. Are you currently using a C- PAP machine now? Yes [ ] No [ ]
3. Do you snore loudly or have been told that you snore? Yes [ ] No [ ]
4. Do you ever awaken with a sensation of gasping or choking? Yes [ ] No [ ]
5. Has anyone ever noticed that you stop breathing during sleep? Yes [ ] No [ ]
6. Do you often wake up with dry mouth? Yes [ ] No [ ]
7. Do you find your sleep to be non-refreshing? Yes [ ] No [ ]
8. Do you often feel tired, fatigued, or sleeping during the day? Yes [ ] No [ ]
9. Do you ever fall asleep or nod off in situations where you did not intend to? Yes [ ] No [ ]
10. Do you have (or being treated for) high blood pressure and / or diabetes? Yes [ ] No [ ]

If you answered YES to 3 or more questions, your dentist will discuss the different options available to have you evaluated for the presence of Obstructive Sleep Apnea.

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717-656-0005 | 717-656-2406 (fax) | 912 W. Main Street, Ste. 404 | New Holland PA 17557

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