Enhancing your life, health and smile.

PATIENT QUESTIONNAIRE

Patient Name: ______________________________ Date of birth: ______________

Phone: (H) ______________ (W) ______________ (C) ______________

Physician (GP) Name: ______________________________

Physician (GP) Address: ______________________________ Phone: ______________

Referring Specialist Physician's Name: ______________________________ Phone: ______________

Medical Conditions

Do you have any condition(s) that your GP is aware of?

Respiratory .... ❍ Yes ❍ No
Cardiovascular .... ❍ Yes ❍ No
Renal .... ❍ Yes ❍ No
Digestive .... ❍ Yes ❍ No
Neurological .... ❍ Yes ❍ No

Please tick yes or no. (You may need to ask your bed partner for some of these answers.)

1. Do you snore or have you been told you snore? .... ❍ Yes ❍ No
2. Do you snore only when you are lying on your back? .... ❍ Yes ❍ No
3. Do you snore loudly? .... ❍ Yes ❍ No
4. Do you snore every night? .... ❍ Yes ❍ No
5. Have you been told you stop breathing or gasp during sleep? .... ❍ Yes ❍ No
6. Has your partner had to move to another room during the night? .... ❍ Yes ❍ No
7. Have you had or been treated for high blood pressure? .... ❍ Yes ❍ No
8. Do you doze off unintentionally during the day? .... ❍ Yes ❍ No
9. Do you often wake feeling tired? .... ❍ Yes ❍ No
10. Do you often wake in the morning with a headache? .... ❍ Yes ❍ No
11. Do you have problems concentrating for long periods of time? .... ❍ Yes ❍ No
12. Do you feel pain in your jaw joints (area of the ear)? .... ❍ Yes ❍ No
13. Do you grind or clench your teeth in your sleep? .... ❍ Yes ❍ No
14. Have you ever been diagnosed with, or do you suspect you have OSA?* .... ❍ Yes ❍ No
15. Have you ever been seen by a specialist for snoring or OSA?* .... ❍ Yes ❍ No
16. Have you ever had a sleep study? .... ❍ Yes ❍ No
17. Have you ever been treated for snoring, OSA or a sleep disorder? .... ❍ Yes ❍ No

*If yes, where and when? ______________________________

Family History

Have any family members had heart disease/high blood pressure/diabetes? .... ❍ Yes ❍ No
Do any family members snore, have OSA or a sleep disorder? .... ❍ Yes ❍ No

*If yes, who? ______________________________

Personal Information

Weight: ________ Height: ________ Neck circumference: ________ (Male greater than 43cm / Female greater than 41cm)

Alcohol consumption (units per week): ________ Smoking consumption (cigarettes/cigars per week): ________