Where and when? Were you diagnosis with obstructive sleep apnea? Y / N
List any other diagnoses Have you been treated with a CPAP machine? Y / N
Are you currently using a CPAP? Y / N If not,
why_____
Have you had a surgery for apnea? Y / N Have you ever tried a dental device? Y / N
How loud is your snoring? No snoring Mild Moderate Loud Very Loud
How long have you been told you snore?
Has your snoring worsen over time? Y / N
Have you ever awakened choking or gasping sound during sleep? Y / N
Has anyone ever told you that your breathing Pauses during sleep? Y / N
Have your gained or lost weight in the last year? Y / N If yes how much?
What time do you usually to go to sleep on: Weekdays Weekends
What time do you usually awaken? Weekdays Weekends
Typically about how many hours of sleep do you get on weekdays?
How many times to you wake up at night on average?
How much sleep would you estimate that you get each night? Weekdays Weekends
What usually cause your awakening?
Do you usually have trouble falling back to sleep? Y / N
If you need to use the bathroom, if yes, how many times do you usually need to go at night?
Have you been feeling tired or sleepy? Y / N
Do you take naps? N / Y If yes, how long? How many days per week do you usually nap?
How many times per day? Do you doze off while driving? Y / N
Have you ever taken medications to improve your sleep? Y / N If yes, which medications and were they effective?

How likely are you to doze off or fall asleep (not just feel tired) in the following situations?
Note: This refers to your usual way of life in recent times. If you have not done some of these things recently, try to determine the ways in which might be in these situations.

	No Chance	**Slight Chance**	**Moderate Chance**	**High Chance**
Sitting and reading	**0**	**1**	**2**	**3**
Watching Television				
Sitting inactive in a public place (theater, meeting or bus)				
Riding as a passenger in a car for an hour without a break				
Lying down to rest in the afternoon				
Sitting quietly after lunch without alcohol				
Sitting and talking to someone				
In a car, while stopped for a few minutes in the traffic				
Total Score				

How often does each item apply to you? (Check the number that applies to you)

	Never or **Very Rare**	Times **Weekly**	**Times Monthly**		Never or **Very Rare**	Times **Weekly**	**Times Monthly**
Restless Sleep				Feeling down or sad			
Wake up with dry mouth				Difficulty concentrating/focusing			
Wake up with sore throat				Difficulty with memory			
Wake up with morning headache				Irritable most of the day			
Wake up feeling non-restful				Erectile dysfunction (men only)			
Difficulty waking up				Sleep walking			
Nasal or Sinus Congestion				Sleep talking			
Heartburn				Leg cramps			
Clenching/Grind teeth when sleeping				Restlessness or discomfort of the legs at bedtime			
Nightmares				Urges to move legs			
Acting out dreams while sleeping				Momentary paralysis when falling asleep			
Feeling tired or sleepy				Sudden muscle weakness brought on by strong emotions			