Patient Name: _____ Date: _____ Date of Birth: _____

Sleep Quality Questionnaire

Height: _____ feet _____ inches

Weight: _____ pounds

Age: _____

Gender: Male / Female

BMI: _____ (if known)

Collar size of shirt: S, M, L, XL, or _____ inches / cm (if known)

1. Do you snore loudly (loud enough to be heard through doors)? Yes / No
2. Do you often feel tired, fatigued, or sleepy during the daytime? Yes / No
3. Has anyone observed you stop breathing during your sleep? Yes / No
4. On average I get _____ hours of quality sleep per night.
5. Most nights I wake at least one time after going to sleep before I am supposed to wake up. Yes / No
6. I usually wake up feeling rested and ready for the day. Yes / No
7. Do you have or are you being treated for high blood pressure? Yes / No
8. Do you have a BMI greater than 35 kg/m2? Unknown / Yes / No
9. Do you have a family history of stroke or heart attack? Yes / No
10. Do you suffer from depression? Yes / No
11. Have you been previously diagnosed with sleep apnea? Yes / No
12. Are you currently using oxygen or mouth guard therapy for sleep apnea, snoring, or respiratory concerns at night? Yes / No

Other comments regarding sleep quality:

_____

_____

_____

_____

_____

_____