Patient Name: _____ Date:_____

1. Do you snore or have you been told you stop breathing while sleeping?
   Yes_____ No_____

2. Do you wake up tired/exhausted in the morning or often tired in the afternoon?
   Yes_____ No_____

3. Do you have High Blood Pressure?
   Yes_____ No_____

4. Can you fall asleep in less than 5 minutes?
   Yes_____ No_____

5. Do you grind your teeth?
   Yes_____ No_____

6. Do you have trouble losing weight?
   Yes_____ No_____

7. Do you have sleep apnea?
   Yes_____ No_____

Did you know that this dental practice can help you with these problems?