ODOM
DENTAL SLEEP MEDICINE
Snoring | Sleep Apnea | Sleep Bruxism | CPAP Intolerance

1. Sleep Health Questionnaire

Patient Name: _____ Date: _____

Have you been diagnosed or treated for any of the following conditions?

☐ High Blood Pressure	☐ Acid Reflux (GERD)	☐ Stroke/Heart Disease
☐ Diabetes	☐ Depression	☐ Sleep Apnea
☐ Daytime Drowsiness	☐ Insomnia	☐ Memory Loss

Have there been any recent changes in your medical history? Yes ◯ No ◯
(Please elaborate on the back of this form) Yes ◯ No ◯

Are you aware, or have you been told that you grind your teeth at night? Yes ◯ No ◯
If yes, do you wear a night guard? Yes ◯ No ◯

Have you ever had a problem with your jaw joint (TMD / TMJ) Yes ◯ No ◯

Do you know, or have you been told that you snore? Yes ◯ No ◯

If yes, how often: Rarely ☐ Sometimes ☐ Often ☐ Most Nights ☐

Are you interested in a non-surgical way to stop your spouse, or you from snoring? Yes ◯ No ◯

Have you been told that you stop breathing or gasp for breath while sleeping? Yes ◯ No ◯

Does anyone in your family snore or have a history of snoring? Yes ◯ No ◯

How would you rank your quality of sleep on most nights?

(Check one) 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (Best)

On an energy level, 10 being the most active and energetic. How would you rate yourself on most days?

(Check one) 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (Best)

Have you ever been diagnosed with a sleep disorder? Yes ◯ No ◯
If yes, have you ever been prescribed CPAP therapy? Yes ◯ No ◯

If yes, how often do you wear your CPAP?
Every Night ☐ Most Nights ☐ A Couple of Nights per week ☐ Never ☐

Do you awaken with headaches or have migraines regularly? Yes ◯ No ◯ If yes, how often:
Rarely ☐ Occasionally ☐ Often ☐

Please list any medications that you take and the condition for which they are taken:

CONDITION	MEDICATION	CONDITION	MEDICATION