**Name:** _____

## Patient Questionnaire

Have you ever been diagnosed with Obstructive Sleep Apnea? Yes ☐ No ☐

Do you use a CPAP machine? Yes ☐ No ☐

Have you ever been told that you snore excessively, or that your breathing is interrupted while you sleep? Yes ☐ No ☐

Do you feel sleepy or fatigued during the day? Yes ☐ No ☐

Do you doze off while reading, watching television or driving? Yes ☐ No ☐

Do you awake with a headache? Yes ☐ No ☐

Do you awake gasping for air? Yes ☐ No ☐

Do you awake in the morning without feeling refreshed? Yes ☐ No ☐

Do you snore or wake up tired? Yes ☐ No ☐

Do you have high blood pressure? Yes ☐ No ☐

Are your front teeth straight and even in length? Yes ☐ No ☐

Are your teeth all the same color? Yes ☐ No ☐

Are any fillings you can see a different color match than your teeth? Yes ☐ No ☐

Do any unsightly restorations show on your back teeth when you smile broadly or laugh? Yes ☐ No ☐

Are there any areas where the gum is receding from the teeth? Yes ☐ No ☐

Do you find yourself clenching or grinding your teeth, or have you ever been told you do? Yes ☐ No ☐

If you could change anything about your smile, what would you most like to change?