LOMA LINDA UNIVERSITY CENTER FOR DENTISTRY AND ORTHODONTICS
SLEEP APNEA QUESTIONNAIRE

Name:_____ Today's Date:_____

1. Do you find your sleep apnea device comfortable?..... ☐ Yes ☐ No
   Explain: _____
2. Are you having jaw pain?..... ☐ Yes ☐ No
   Explain:_____
3. When you wake, do you feel rested?..... ☐ Yes ☐ No
   Explain: _____
4. Are you aware of snoring?..... ☐ Yes ☐ No
   Explain: _____
5. While you sleep, are you aware of the fact that you stop breathing..... ☐ Yes ☐ No
   Explain:_____
6. Are you tired throughout the day? ..... ☐ Yes ☐ No
   Explain:_____
7. Are you currently using a CPAP?..... ☐ Yes ☐ No
   Explain: _____
8. Do you experience headaches?..... ☐ Yes ☐ No
   Explain: _____
9. Are you taking any sleep aids?..... ☐ Yes ☐ No
   Explain: _____
10. Have you had any recent crowns, bridges, or teeth removed? ..... ☐ Yes ☐ No
    Explain: _____
11. Have you had any new dental work done?..... ☐ Yes ☐ No
    Please list last Dentist visited and the treatment performed: _____
    _____
12. What is your current pain rating? (Please circle) 0 1 2 3 4 5 6 7 8 9 10
13. On average, how many hours of sleep do you get each night? _____
14. On average, how many times do you wake up each night? _____
15. When you wake up during the night, what causes you to wake? _____
    _____