Implants done right the first time

Office of **Keerthi Senthil DDS, MS**
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Today's Date:_____

Sleep Health Questionnaire

Patient Name:

Last _____ Middle _____ First _____

Home Phone (include area code) _____

Work Phone (include area code) _____

Mobile Phone (include area code) _____

Address _____ City _____

State _____ Zip Code _____ Email _____

Mailing Address _____

Date of Birth _____ Sex M◯ F◯ Height _____ Weight _____

Occupation _____

Employer Name, Address _____

Marital Status: ◯Single ◯Married ◯Divorced ◯Separated

Social Security Number	Emergency Contact	Relationship to Patient
_____	_____	_____
Their Home Phone	**Their Cell Phone**	
_____	_____	

Have you ever fallen sleep or nodded off while driving?	◯Yes ◯No	6
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	◯Yes ◯No	6

Do you feel excessively tired during the day?	◯ Yes ◯ No	4
Do you snore or have been told that you snore?	◯ Yes ◯ No	4
Have you had weight gain and found it difficult to lose?	◯ Yes ◯ No	2
Have you taken medication for, or been diagnosed with high blood pressure?	◯ Yes ◯ No	2
Do you kick or jerk your legs while sleeping?	◯ Yes ◯ No	3
Do you feel burning, tingling or crawling sensation in your legs when you wake up?	◯ Yes ◯ No	3
Do you wake up with headaches during the night or in the morning?	◯ Yes ◯ No	3
Do you have trouble falling asleep?	◯ Yes ◯ No	4
Do you have trouble staying asleep once you fall asleep?	◯ Yes ◯ No	4
Have you been told you stop breathing in your sleep?	◯ Yes ◯ No	8

TOTAL SCORE: _____

Risk Level / **Score**	**Low** **0-7**	**Medium** **8-11**	**High** **12-15**	**Severe** **16+**

Signs and Symptoms. Please indicate all that apply

- ☐ Family History of Snoring or Sleep Apnea
- ☐ Stroke/ Heart Disease
- ☐ Un-refreshed Sleep
- ☐ Depression
- ☐ Grind Teeth
- ☐ Acid Reflux
- ☐ Hypertension
- ☐ Snoring
- ☐ Diabetes

Sleep History. Please indicate all that apply

Have you ever been diagnosed with a Sleep Disorder?
Yes ◯ No ◯

Are you currently using a CPAP machine?
Yes ◯ No ◯

Do you use your CPAP less than 5 times a week?
Yes ◯ No ◯

Would you prefer an oral device or appliance?
Yes ◯ No ◯

Patient's Signature _____ Date _____