Name: $\qquad$ Date: $\qquad$
Please specify your answers by ticking the appropriate box.

## Symptoms:

During the past few weeks:
Never
Rarely
Sometimes
Often

1. Have you snored or have you been told that you do?
2. Have you had morning
fatigue, fogginess or woken up feeling unrefreshed?
3. Have you fallen asleep during the day, particularly when not busy?
4. Have you been told that you stop breathing while asleep?
5. Teeth Discomfort?

If sometimes or always, please rate the severity of the side effect:
6. Jaw Discomfort?

Not at all
Always
Sometimes
Mild Moderate
Severe

Not at all
Always

If sometimes or always,
Mild
Moderate
Severe please rate the severity of the side effect:
7. Gum Discomfort?

If sometimes or always, please rate the severity of the side effect:
8. Ear Pain?

If sometimes or always,
Not at all
Always
Sometimes
Mild Moderate Severe
please rate the severity of the side effect:
9. Excessive Salivation?

Not at all
Always

If sometimes or always,
Mild
Sometimes
please rate the severity of the side effect:

Not at all
Always
Sometimes
Mild
Moderate Severe

Severe
10. A sense of inadequate airway?

If sometimes or always, please rate the severity of the side effect:

Not at all

Mild
Moderate
Severe

Sometimes

Always
$\left.\begin{array}{llll}\text { Sleep Quality } \\ \text { It is easy for you to get } \\ \text { to sleep? }\end{array} \quad \square \quad \square\right)$

## Comment

## Yes

