Name:			Date:				
Plea	se specify your answers by t	ticking the ap	propriate box	•			
Sym	iptoms:						
During the past few weeks:		Neve	er	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?	Not at all	Sometimes	Always			
	If sometimes or always, please rate the severity of the side effect:	Mild	Moderate	Severe			
6.	Jaw Discomfort?	Not at all	Sometimes	Always			
	If sometimes or always, please rate the severity of the side effect:	Mild	Moderate	Severe			
7.	Gum Discomfort?	Not at all	Sometimes	Always			
	If sometimes or always, please rate the severity of the side effect:	Mild	Moderate	Severe			
8.	Ear Pain?	Not at all	Sometimes	Always			
	If sometimes or always, please rate the severity of the side effect:	Mild	Moderate	Severe			
9.	Excessive Salivation?	Not at all	Sometimes	Always			
	If sometimes or always, please rate the severity of the side effect:	Mild	Moderate	Severe			

Snoring Obstructive Sleep Apnea Evaluation

10. A sense of inadequate airway?	Not at all	Sometimes	Always
If sometimes or always, please rate the severity of the side effect:	Mild	Moderate	Severe

Sleep Quality

Yes

No

It is easy for you to get to sleep?			
Are you waking up during the night?			
Do you have to go to the bathroom at night?			
Are you dreaming?	_	-	
	U	U	
Do you remember your	-	-	
dreams?			
When you wake up are you feeling refreshed/ rested?		•	
Are you feeling the need for a daytime nap?			
Do you feel able to cope with your daily activities/ responsibilities easily?			

Comment