Patient Name: _____ Phone Number: _____

Date of Birth: _____ Email Address: _____

OSA Sleep Assessment

1. Have you ever had a sleep study done?	**YES**	**NO**
2. Are you currently using a CPAP machine?	**YES**	**NO**
3. Do you snore loudly or have been told that you snore?	**YES**	**NO**
4. Do you ever awaken with the sensation of choking or gasping?	**YES**	**NO**
5. Has anyone ever noticed that you stopped breathing during sleep?	**YES**	**NO**
6. Do you often wake up with dry mouth?	**YES**	**NO**
7. Do you find your sleep to be non-refreshing?	**YES**	**NO**
8. Do you often feel tired, fatigued or sleepy during the day?	**YES**	**NO**
9. Do you ever fall asleep or nod off in situations where you did not intend to?	**YES**	**NO**
10. Do you have (or are you being treated for) high blood pressure and/or diabetes?	**YES**	**NO**

If you have answered YES on two or more of the above questions, you may be suffering from a sleep disorder known as obstructive sleep apnea.

Your doctors or one of our treatment coordinators will speak with you today about a possible diagnosis and treatment options.

Obstructive Sleep Apnea can be the underlying cause for many other problems, including

- *Daytime Sleepiness*
- *Weight Gain*
- *Fatigue*
- *Obesity*
- *Diabetes Melitus*
- *Respiratory Problems*
- *Hypertension*
- *Heart Disease*
- *Restless Leg Syndrome*
- *Lack of Concentration*

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DENTAL SLEEP MEDICINE ASSOCIATES