PRINCETON PARK DENTAL ASSOCIATES, P.A.
SLEEP DISORDERED BREATHING HISTORY FORM

What is your weight? _____ pounds Body Mass Index _____
BMI calculator @www.nhlbisupport.com/bmi

What is your height? _____ feet _____inches

What is your neck circumference/collar size in inches? _____

PLEASE CIRCLE THE ANSWER THAT BEST APPLIES TO YOU

1. Do you smoke? Yes No If yes, how much do you smoke a day? _____
2. How much alcohol do you drink in a day?_____
3. Has anyone ever noticed that you have episodes of not breathing at night?
   Never Rarely Sometimes Often
4. Have you experienced waking up choking?
   Never Rarely Sometimes Often
5. Do you regularly experience sleep that feels unrefreshed upon waking?
   Never Rarely Sometimes Often
6. Are you chronically tired? Yes No
7. How many times do you awaken from sleeping on an average night? _____
   How many of these times are to use the bathroom? _____
   Do you have trouble getting back to sleep? Yes No
8. Do you snore?
   Never Rarely Sometimes Often
9. On a scale from 1 to 10, how would a significant other rate your snoring?
   1 (heavy breathing) and 10 (ear plugs and sleeping in another room do not help)
   1 2 3 4 5 6 7 8 9 10
10. What are your normal sleeping hours? _____p.m. (a.m.) to _____ a.m. (p.m.)
11. Can you breathe through your nose? Yes No
12. Do you experience rhinitus, hayfever, or allergies? Yes No
13. When you sleep, what posture or position do you favor? Side Back Stomach

If you do not understand these questions, please ignore them:

1. Have you had difficulty using a CPAP machine? Yes No
2. Have you had previous operations for snoring and/or sleep apnea? Yes No
   (e.g., UPPP / Palatal pillars / Uvulectomy / T & A) Dates_____
3. Have you ever worn an oral appliance? Yes No