

## SLD Sleep and Bite Questionnaire

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Has anyone ever told you that you snore?  Yes  No

Has anyone in your family been diagnosed with sleep apnea?  Yes  No

Do you have high blood pressure?  Yes  No

If yes, how are you currently treating it?

Have you been diagnosed with sleep apnea?  Yes  No \_\_\_\_\_

Have you noticed a change in how your teeth come together?  Yes  No

Do you have pain or noise in your jaw joint?  Yes  No

Do you grind or clench your teeth at day or night?  Yes  No

Do your jaw muscles feel tired after eating?  Yes  No

Do you get headaches or migraines?  Yes  No

Have you ever worn a bite splint or night guard?  Yes  No

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Patient's Signature

Printed Name

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Date

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