VIVOS®

# Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____yes _____no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____yes _____no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____yes _____no

Are you happy with your CPAP or Sleep Appliance? _____yes _____no

If you are not happy - why? _____

_____

_____

How often do you get out of bed to use the restroom during the night? _____

| | Yes | No |
|---|---|---|
| Do you usually wake feeling tired and unrested? | ☐ | ☐ |
| Do you habitually snore? | ☐ | ☐ |
| Have you been diagnosed with Hypertension/High Blood Pressure? | ☐ | ☐ |
| Do you often suffer from waking headaches? | ☐ | ☐ |
| Do you regularly experience daytime drowsiness or fatigue? | ☐ | ☐ |
| Do you have blocked nasal passages? | ☐ | ☐ |
| Has anyone observed you stop breathing during your sleep? | ☐ | ☐ |
| Do you ever wake up choking or gasping? | ☐ | ☐ |
| Do you grind your teeth while sleeping? | ☐ | ☐ |
| Is your neck circumference greater than 40 cm/ 15.75" ? | ☐ | ☐ |
| Is your Body Mass Index (BMI) more than 35? | ☐ | ☐ |

BMI Formula BMI = (your weight in pounds X 703) / (your height in inches X your height in inches)