

## Patient Questionnaire

Have you ever been told that you snore excessively, or that your breathing is interrupted while you sleep? Yes  No

Do you feel sleepy or fatigued during the day? Yes  No

Do you doze off while reading, watching television or driving? Yes  No

Do you awake with a headache? Yes  No

Do you awake gasping for air? Yes  No

Do you awake in the morning without feeling refreshed? Yes  No

Do you snore or wake up tired? Yes  No

Do you have high blood pressure? Yes  No

Are your front teeth straight and even in length? Yes  No

Are your teeth all the same color? Yes  No

Are any fillings you can see a different color match than your teeth? Yes   
No

Do any unsightly restorations show on your back teeth when you smile broadly or laugh? Yes  No

Are there any areas where the gum is receding from the teeth? Yes  No

Do you find yourself clenching or grinding your teeth, or have you ever been told you do? Yes  No

If you could change anything about your smile, what would you most like to change?

