Dental
SLEEP MEDICINE
of Michigan P.C.

SNORING & SLEEP APNEA TREATMENT

CURRENT SLEEP SYMPTOMS

NAME: ___________________ **Date:** ________ **BIRTHDAY:** __________________

SYMPTOM	Y	N	SYMPTOM	Y	N
Difficulty breathing during sleep			Morning headaches		
Stops breathing during sleep			Learning issues		
Snores			Resists going to bed		
Restless sleep			Teeth grinding		
Sweating during sleep			Wets the bed		
Daytime sleepiness			Gets out of bed at night		
Nightmares			Trouble getting up in the morning		
Sleepwalking			Falls asleep in school		
Sleep talking			Naps after school		
Screaming during sleep			Behavioral Issues – ADD/ ADHD		
Kicks legs during sleep/ uncomfortable feeling in legs			Reports feeling unable to move when falling asleep		

What allergies does your child have?
Drugs: ___________________________ Environmental: ______________________________
Does your child have Asthma? Y N
What diagnosed health conditions does your child have?

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What surgeries has your child had? ____
Has your child had negative dental experiences? Y N

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Physician's name: _______________________ Phone: __________________________
Date of last visit: _______________________

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