Sleep Assessment

Patient Name: _____ Date_____

1. On a scale of 1 to 10, 10 being the best, how is your overall quality of sleep?

_____

2. Does anyone in your immediate family (parents, siblings, etc.) snore of have they been diagnosed with obstructive sleep apnea?

_____

3. On a scale of 1 to 10, 10 being the best, how do you rank your overall daytime energy level?

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