Your Sleep Evaluation

1. Do you snore? **Yes** **No**
2. Do you have excessive daytime sleepiness? **Yes** **No**
3. Do you frequently have morning headaches? **Yes** **No**
4. Have you ever had a sleep study? **Yes** **No**
5. Have you been diagnosed with sleep apnea? **Yes** **No**
6. Have you worn a CPAP? **Yes** **No**
   If yes, is it comfortable? **Yes** **No**
   Do you use it every night? **Yes** **No**
   Do you remove your CPAP during the night? **Yes** **No**

If you answered Yes to any of the previous questions, please rate the following:

(Scoring: 0 = would never feel tired; 1 = light chance of being tired; 2 = moderate chance of being tired; 3 = high chance of being tired)

- Sitting and reading **0 1 2 3**
- Watching Television **0 1 2 3**
- Sitting in a public place **0 1 2 3**
- Lying down to rest in the afternoon **0 1 2 3**
- Sitting and talking to someone **0 1 2 3**
- Sitting quietly after lunch **0 1 2 3**
- In a car while stopped in traffic **0 1 2 3**
- As a passenger in a car for an hour **0 1 2 3**

Your Smile Evaluation

1. Are you pleased and confident with the way your teeth look when you smile? **Yes** **No**
2. Do you have some unwanted spaces or gaps between your teeth? **Yes** **No**
3. Is there a chip or crack that you would like to have repaired? **Yes** **No**
4. Are you concerned about one or more than one tooth that is discolored? **Yes** **No**
5. Do you have some unattractive discolored metal or tooth colored fillings? **Yes** **No**
6. Do you have teeth that are slightly out of line, overlapping, or protruding? **Yes** **No**
7. Do you have some missing teeth that should be replaced? **Yes** **No**
8. Could your smile be improved if your teeth were: Whiter? Longer? Shorter? Wider? Narrower?