Patient's Questionnaire

The answers to this questionnaire will provide us with essential diagnostic information so as to determine your snoring pattern and the specific design of the Silensor that you require.

We would ask that once you have printed off this questionnaire that you discuss the questions with your partner and/or other members of your household.

Patients Name: _____

Dentist's Name: _____

Date: _____

		Yes	No
1.	Do you only snore when lying on your back? (please ask your partner, if possible)	☐	☐
2.	Do you only snore when your mouth is open? (please ask your partner, if possible)	☐	☐
3.	Do you snore noisily? (please ask your partner, if possible)	☐	☐
4.	Do you fell tired in the morning?	☐	☐
5.	Do you wake up in the morning with a headache?	☐	☐
6.	Do you have problems when concentrating for long periods of time?	☐	☐
7.	Does sleep suddenly overcome you during the day, do you doze off unintentionally during the day?	☐	☐
8.	Are breathing breaks observed during your sleep and do you gasp for air afterwards?	☐	☐
9.	Do you feel pain in the area of your jaw joints (area of the ear)?	☐	☐
10	Do you feel any tension or strain in your cheek muscles in the morning (area at the side of your face)?	☐	☐
11	Do you grind or clench your teeth in your sleep? (please ask your partner, if possible)	☐	☐

12. Your weight: in Kg _____ in stones _____

Your height: in metres _____ in feet _____

Your date of birth: _____

Please return this completed form to your dentist

Silensor • Marchpen House
45-47 Friern Barnet Road • London N11 3EG
Tel: 020 8361 4649 • Fax: 020 8361 4145
Website: http://www.silensor.co.uk
e-mail: info@silensor.co.uk