PATIENT USE ONLY

MYOBRACE® SLEEP QUESTIONNAIRE

Please answer the following questions on your average sleep habits/quality during the past month.

Going to sleep		YES	NO	Unsure
Do you have any problems going to bed or falling asleep?		☐	☐	☐
Do you have an irregular bedtime?		☐	☐	☐
Do you have an irregular wake time?		☐	☐	☐
Does your bedtime/wake time differ greatly between weekdays and weekends?		☐	☐	☐
While sleeping		**YES**	**NO**	**Unsure**
Do you often wake up at night after falling asleep?		☐	☐	☐
Do you snore while sleeping?		☐	☐	☐
Please answer these > additional questions if you answered **'Yes'** to the question above.	Do you snore on most nights (more than three nights per week)?	☐	☐	☐
	Do you snore for more than half of the night's sleep duration?	☐	☐	☐
	Do you snore loudly?	☐	☐	☐
Do you have heavy, loud breathing habits while sleeping?		☐	☐	☐
Do you have your mouth open while sleeping?		☐	☐	☐
Do you have difficulty breathing at night while sleeping?		☐	☐	☐
Has it been reported that you stop breathing or gasp during sleeping?		☐	☐	☐
Do you have regular nightmares, sleepwalk, or have any other unusual sleep behaviours?		☐	☐	☐
Do you think you are not getting enough sleep?		☐	☐	☐
Have you ever had a sleep study (PSG or portable take home study)?		☐	☐	☐
While awake		**YES**	**NO**	**Unsure**
Do you feel overtired or sleepy during the day?		☐	☐	☐
Do you wake up feeling unrefreshed in the morning?		☐	☐	☐
Do you find it difficult to wake up in the morning?		☐	☐	☐
Do you wake up with headaches in the morning?		☐	☐	☐
Do you take excessive naps during the day?		☐	☐	☐
Do you tend to breathe through the mouth while awake?		☐	☐	☐
Do you have a dry mouth when you wake up in the morning?		☐	☐	☐
Do you occasionally fall asleep during the day...	... when you are busy or active?	☐	☐	☐
	... when you are driving or stopped at a traffic light?	☐	☐	☐
	... when you are sitting and talking to someone?	☐	☐	☐
	... when you are sitting or inactive in a public place?	☐	☐	☐
Have you been previously or currently treated for high blood pressure?		☐	☐	☐
Are you overweight?		☐	☐	☐

MYOBRACE_FORM_PQ_A_0624_ENG_V1.0.0

Date:	Name:	Age:	D.O.B (DD/MM/YYYY):
Address:		Postcode:	Mobile Number:
Referred by:		Health Fund:	

myobrace®

STRAIGHT TEETH
THE NATURAL WAY®
www.myobrace.com

MRC® MYOFUNCTIONAL RESEARCH CO.
INNOVATIVE DENTAL APPLIANCE TECHNOLOGY AND EDUCATION