urbansmiles
FAMILY DENTAL

Patient's *Assessment of Sleep Habits Forms*
After *NightLase Treatment(s) for Snoring*

Patients Name: _____ Date: _____ Nightlase Tx#:____

The purpose of this form is to provide information on the quality of your sleep and snoring levels since you have been treated with the NightLase therapy. **Please answer these questions as they pertain to your observations and feelings as they are at this time.** If you have a sleep partner it would be beneficial to have them complete the sleep partner's form that asks very similar questions on their perspective of your sleep habits at this time.

Overall, how would you **now rate the quality** of your sleep? (10 being highest)
10 9 8 7 6 5 4 3 2 1 0

How would you **rate the reduction in snoring since** your first NightLase Treatment?
100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

How often do you snore? (Very Often=10, Occasionally=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, how would you rate **the noise level of your snoring?** (10 being highest)
10 9 8 7 6 5 4 3 2 1 0

Now, how often **does your snoring wake you up** at night? (Very Often=10, Occasionally=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, do you **ever gasp for breath at night?** (Very Often=10, Occasionally=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, on average how many times **do you get up during the night?**
10 9 8 7 6 5 4 3 2 1 0

Now, do you **wake up with a dry mouth or sore throat?** (Always=10, Sometimes=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, how often do you **have morning headaches?** (Always=10, Sometimes=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

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Now, do you feel a lack of sleep or **wake up tired?** (Always=10, Sometimes=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, do you have **difficulty waking up in the morning?** (Always=10, Sometimes=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, do you **feel sleepy/tired/fatigued during the day?** (Always=10, Sometimes=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, do you **fall asleep during the day at unwanted times?** (Always=10, Sometimes=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, How frequently does **your snoring disturb your sleep partner now?** (10 being often)
10 9 8 7 6 5 4 3 2 1 0

Other Comments you feel would be beneficial:
_____
_____
_____
_____

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*Sleep **Partner's** Assessment of the Patient's Sleep Habits*
***After** NightLase Treatment(s) for Snoring Form*

Patients Name: _____ Date: _____ Nightlase Tx#:____

The purpose of this form is to provide information on the quality of sleep and snoring levels since the patient has been treated with NightLase therapy. **Please answer these questions as they pertain to your observations and feelings as they are, at this time.**

Overall, how would you **now rate the quality** of the patient's sleep? (10 being highest)
10 9 8 7 6 5 4 3 2 1 0

How would you **rate the patient's reduction in snoring since** their first NightLase Treatment?
100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

How often do they snore? (Very Often=10, Occasionally=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, how would you rate **the noise level of the patient's snoring?** (10 being highest)
10 9 8 7 6 5 4 3 2 1 0

Now, how often **does their snoring wake you up** at night? (Very Often=10, Occasionally=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, do they **ever gasp for breath at night?** (Very Often=10, Occasionally=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, on average how many times **do they get up during the night?**
10 9 8 7 6 5 4 3 2 1 0

Now, do they complain about **waking up with a dry mouth or sore throat?** (Always=10, Sometimes=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, how often do they complain about **having morning headaches?** (Always=10, Sometimes=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

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*Sleep **Partner's** Assessment of the Patient's Sleep Habits*
***After** NightLase Treatment(s) for Snoring Form*

Now, do they feel a lack of sleep or **wake up tired?** (Always=10, Sometimes=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, do they have **difficulty waking up in the morning?** (Always=10, Sometimes=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, do they complain about **feeling sleepy/tired/fatigued during the day?** (Always=10, Sometimes=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, do they **fall asleep during the day at unwanted times?** (Always=10, Sometimes=5, Never=0)
10 9 8 7 6 5 4 3 2 1 0

Now, how frequently does **their snoring disturb your sleep?** (10 being often)
10 9 8 7 6 5 4 3 2 1 0

Other Comments you feel would be beneficial:
_____
_____
_____
_____