

## Sleep Health Questions

S (snore)	Have you been told that you occasionally or frequently snore?	<input type="checkbox"/> Yes/No <input type="checkbox"/>
T (tired)	Are you often tired during the day?	<input type="checkbox"/> Yes/No <input type="checkbox"/>
O (observed)	Do you know if you ever gasp or stop breathing during sleep or has anyone observed you gasp or stop breathing while you are asleep?	<input type="checkbox"/> Yes/No <input type="checkbox"/>
P (pressure)	Have you ever had high blood pressure or are you on medication to control high blood pressure?	<input type="checkbox"/> Yes/No <input type="checkbox"/>
G (grinding)	Are you aware that you clench or grind your teeth while sleeping?	<input type="checkbox"/> Yes/No <input type="checkbox"/>