

**Adult Airway Questionnaire**

**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sex:** M F **Weight:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Height:** \_\_\_\_\_\_\_\_\_\_\_\_\_  **BMI:** \_\_\_\_\_\_\_\_\_\_

**Occupation:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you breathe through your mouth?**

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**Do you frequently get a dry throat or non-productive cough?**

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**Do you have any nasal allergies?**

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**Do you snore or have you been told you snore while sleeping?**

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**Do you stop or pause your breathing while sleeping?**

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**Do you wake up fatigued?**

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**Do you have morning tension or migraine headaches?**

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**Do you easily get tired or fall asleep during the day?**

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**Do you clench or grind the teeth during the night?**

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**Do you clench or grind the teeth during the day?**

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**Do you have any facial pain?**

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**Do you usually drink alcohol or take sleep aids before going to bed?**

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**Do you suffer from hypertension?**

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**Have you been diagnosed with Chronic Fatigue Syndrome, Irritable Bowel Syndrome, Fibromyalgia or Temporomandibular Syndrome?**

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