iSleep Dental Program—Chair side Screener

To be utilized/completed by a dental professional during an office visit

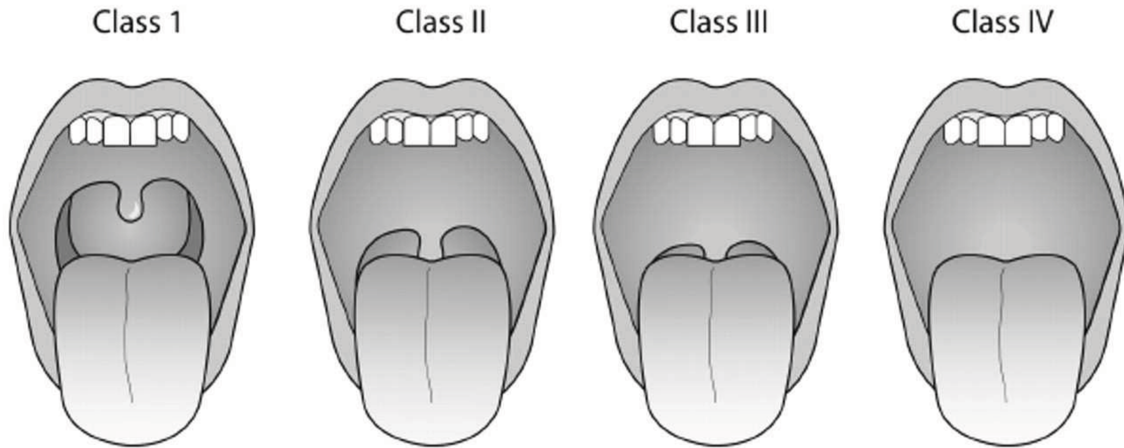
Does the patient present with and/or have a history of any of the following:

(Score each "Yes" response as **1** point)

Obesity (BMI > 25)	☐ **Yes**	☐ **No**	Unrefreshing Sleep	☐ **Yes**	☐ **No**
Hypertension/HBP	☐ **Yes**	☐ **No**	Other Cardiovascular issues	☐ **Yes**	☐ **No**
Diabetes	☐ **Yes**	☐ **No**	Waking up with a dry mouth	☐ **Yes**	☐ **No**
Dyslipidemia	☐ **Yes**	☐ **No**	GERD	☐ **Yes**	☐ **No**
Enlarged Tongue	☐ **Yes**	☐ **No**	Nocturia	☐ **Yes**	☐ **No**
Enlarged Uvula	☐ **Yes**	☐ **No**	Enlarged Tonsils	☐ **Yes**	☐ **No**

Score__________

What does the patient's airway look like (Circle):



Scoring: Class I-**1 Point**; Class II- **2 Points**; Class III—**3 Points**; Class IV—**4 Points**

Total Score: ______

If the patient's score is > 6 they should be referred for a sleep evaluation