

Start Time: Stop Time:

Sleep Testing Questionnaire

PRINT IN CAPITAL LETTERS- STAY WITHIN BOX

First Name		Middle Name			Last Name			Tally Risk Points	
Weight (lbs)		Age (Years)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			Neck Size +2 Male > 16.5 +2 Female > 15.0		
Height	Inches	BMI	Date of Birth	Month	Day	Year		Neck Size	Inches

COMPLETELY FILL IN BOX FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?			
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nasal Oxygen Use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insomnia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Restless Leg Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
Narcolepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Morning Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleeping Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Medications e.g., Vicodin, Oxycontin	<input type="checkbox"/> Yes <input type="checkbox"/> No

Epworth Sleepiness Scale: How Likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0= would never doze 1= slight chance of dozing 2= Moderate chance of dozing 3= high chance of dozing

	0	1	2	3
Sitting and Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting, Inactive, in a public place (theater, Meeting, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Frequency	0-1 times/week	1-2 times/week	3-4 times/week	5-7 times/week
On Average in the past month, how often have you snored or been told that you snored?	Never <input type="checkbox"/>	Rarely <input type="checkbox"/> +1	Sometimes <input type="checkbox"/> +2	Frequently <input type="checkbox"/> +3
Do you wake up choking or gasping?	Never <input type="checkbox"/>	Rarely <input type="checkbox"/> +1	Sometimes <input type="checkbox"/> +2	Frequently <input type="checkbox"/> +3
Have you been told you stop breathing in your sleep or wake up choking or gasping?	Never <input type="checkbox"/>	Rarely <input type="checkbox"/> +1	Sometimes <input type="checkbox"/> +2	Frequently <input type="checkbox"/> +3
Do you have problems keeping your legs still at night or need to move them to feel comfortable?	Never <input type="checkbox"/>	Rarely <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Frequently <input type="checkbox"/>

After screening and evaluation of above named patient, I find there is a strong probability for a sleep related breathing disorder. I will refer patient back to their primary care physician or a sleep specialist for further evaluation.	Total all 6 boxes from above	Point Total
	If point total = 4 or 5 (Low Risk), 6 to 10 (High) and 11 or more (Very High Risk)	<input type="text"/>
Dentist Signature	Date	