Medi-Dent Solutions LLC
1050 15th Street Ste 2
Mason City, IA 50401
Ph. (641)450-0280
Fax (641)450-0284

MediDent SOLUTIONS™
Dental Sleep Made Simple

Sleep Testing Questionnaire

PRINT IN CAPITAL LETTERS- STAY WITHIN BOX

First Name	Middle Name	Last Name

Tally Risk Points

Weight (lbs)		Age (Years)		Gender ☐ Male ☐ Female

Neck Size
+2 Male > 16.5
+2 Female> 15.0

Height	Inches	BMI	Date of Birth	Month	Day	Year	Neck Size	Inches

Score ☐

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	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No
Lung Disease	☐ Yes ☐ No	Nasal Oxygen Use	☐ Yes ☐ No
Insomnia	☐ Yes ☐ No	Restless Leg Syndrome	☐ Yes ☐ No
Narcolepsy	☐ Yes ☐ No	Morning Headaches	☐ Yes ☐ No
Sleeping Medication	☐ Yes ☐ No	Pain Medications e.g., Vicodin, Oxycontin	☐ Yes ☐ No

Co-Morbidities
+1 for Each Yes

Score ☐

Do Not Assign Any points for these eight responses

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	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting, Inactive, in a public place (theater, Meeting, etc)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Epworth Score **TOTAL** the values from all 8 questions if 11 or less **Score = 0** If 12 or more **Score = 2**

Score ☐

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 ☐	**Rarely** ☐ +1	**Sometimes** ☐ +2	**Frequently** ☐ +3	**Almost Always** ☐ +4
Do you wake up choking or gasping?				
Never ☐	**Rarely** ☐ +1	**Sometimes** ☐ +2	**Frequently** ☐ +3	**Almost Always** ☐ +4
Have you been told you stop breathing in your sleep or wake up choking or gasping?				
Never ☐	**Rarely** ☐ +1	**Sometimes** ☐ +2	**Frequently** ☐ +3	**Almost Always** ☐ +4
Do you have problems keeping your legs still at night or need to move them to feel comfortable?				
Never ☐	**Rarely** ☐	**Sometimes** ☐	**Frequently** ☐	**Almost Always** ☐

Assign points for each of the first three responses

☐
☐
☐
☐

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)	☐
Dentist Signature / Date		