

Sleep Screening Questionnaire

Please answer the questions below to help us assess the possibility of a sleep disorder which may be related to your dental and overall health. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke. If you are here with your child (under 16), please fill out the lower portion marked "For children only" for your child.

Name: _____ Height: _____ Weight: _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

- | | |
|--------------------------------------|--|
| 0 = I would never doze | 2 = I have a moderate chance of dozing |
| 1 = I have a slight chance of dozing | 3 = I have a high chance of dozing |

Situation	Chance of Dozing
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theater or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____
Total Score	_____

Have you ever been diagnosed with:

	Yes	No
1. Impaired Cognition (i.e. difficulty concentrating or thinking)	<input type="checkbox"/>	<input type="checkbox"/>
2. Mood Disorders/Depression	<input type="checkbox"/>	<input type="checkbox"/>
3. Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
4. Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
5. Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	<input type="checkbox"/>	<input type="checkbox"/>
6. History of Stroke	<input type="checkbox"/>	<input type="checkbox"/>
7. Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
If yes: Did you try to use CPAP	<input type="checkbox"/>	<input type="checkbox"/>
8. TMJ problems significant enough to require treatment	<input type="checkbox"/>	<input type="checkbox"/>
9. Gastric Reflux (GERD) or Heartburn	<input type="checkbox"/>	<input type="checkbox"/>

Are you aware of (or have you been told):

	Yes	No
1. Snoring on a regular basis	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling tired or fatigued on a regular basis	<input type="checkbox"/>	<input type="checkbox"/>
3. Clenching or grinding your teeth (bruxism)	<input type="checkbox"/>	<input type="checkbox"/>
4. Having frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
5. Your neck size being > 17 inches (male) or > 16 inches (female)	<input type="checkbox"/>	<input type="checkbox"/>
6. Anyone in your family having sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
7. Stopping breathing when sleeping/awakening with a gasp	<input type="checkbox"/>	<input type="checkbox"/>

For children only (filled out by parent or guardian)

Are you aware of your child:

	Yes	No
1. Snoring/noisy breathing while sleeping	<input type="checkbox"/>	<input type="checkbox"/>
2. Grinding his or her teeth	<input type="checkbox"/>	<input type="checkbox"/>
3. Wetting the bed	<input type="checkbox"/>	<input type="checkbox"/>
4. Having difficulty in school/learning	<input type="checkbox"/>	<input type="checkbox"/>
5. Being treated for ADD or ADHD	<input type="checkbox"/>	<input type="checkbox"/>
6. Breathing primarily through their mouth	<input type="checkbox"/>	<input type="checkbox"/>
7. Having frequent nightmares/night terrors	<input type="checkbox"/>	<input type="checkbox"/>
8. Having frequent ear aches	<input type="checkbox"/>	<input type="checkbox"/>

- | | | | |
|------------------------------|--|---|--|
| Dental Exam Findings: | <input type="checkbox"/> Evidence of Bruxism | <input type="checkbox"/> Scalloping of the tongue | <input type="checkbox"/> Crowded airway |
| | <input type="checkbox"/> Tori or Bone Loss | <input type="checkbox"/> Anterior wear | <input type="checkbox"/> Retrognathia / Class II |
| | <input type="checkbox"/> Mallampati 3 or 4 | | |