Sleep Screening Questionnaire

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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.

First Name *

Last 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

1 = I have a slight chance of dozing

2 = I have a moderate chance of dozing

3 = I have a high chance of dozing

Situation:

1. Sitting and reading *

○ Would never doze ○ Slight chance of dozing ○ Moderate chance of dozing ○ High chance of dozing

2. Watching TV *

○ Would never doze ○ Slight chance of dozing ○ Moderate chance of dozing ○ High chance of dozing

3. Sitting inactive in a public place (i.e. a theater or a meeting) *

○ Would never doze ○ Slight chance of dozing ○ Moderate chance of dozing ○ High chance of dozing

4. As a passenger in a car for an hour without a break *

○ Would never doze ○ Slight chance of dozing ○ Moderate chance of dozing ○ High chance of dozing

5. Lying down to rest in the afternoon *

○ Would never doze ○ Slight chance of dozing ○ Moderate chance of dozing ○ High chance of dozing

6. Sitting and talking to someone *

○ Would never doze ○ Slight chance of dozing ○ Moderate chance of dozing ○ High chance of dozing

7. Sitting quietly after lunch, without alcohol *

○ Would never doze ○ Slight chance of dozing ○ Moderate chance of dozing ○ High chance of dozing

8. In a car while stopped for a few minutes in traffic *

○ Would never doze ○ Slight chance of dozing ○ Moderate chance of dozing ○ High chance of dozing

Total Score		/24

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Have you ever been diagnosed with:

1. Impaired Cognition (i.e. difficulty concentrating or thinking)

○ Yes ○ No

2. Mood Disorders/Depression

○ Yes ○ No

3. Insomnia

○ Yes ○ No

4. Hypertension (high blood pressure)

○ Yes ○ No

5. Ischemic Heart Disease

○ Yes ○ No

(Coronary Artery Disease/Atherosclerosis)

6. History of Stroke

○ Yes ○ No

7. Sleep Apnea

○ Yes ○ No

8. TMJ problems significant enough to require treatment

○ Yes ○ No

9. Gastric Reflux (GERO) or Heartburn

○ Yes ○ No

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

1. Snoring on a regular basis

○ Yes ○ No

2. Feeling tired or fatigued on a regular basis

○ Yes ○ No

2. Feeling tired or fatigued on a regular basis

○ Yes ○ No

4. Having frequent headaches

○ Yes ○ No

5. Your neck size being greater than 17 inches (male) or greater than 16 inches (female)

○ Yes ○ No

6. Anyone in your family having sleep apnea

○ Yes ○ No

7. Stopping breathing when sleeping/awakening with a gasp

○ Yes ○ No

For children only (filled out by parent or guardian)
Are you aware of your child:

1. Snoring/noisy breathing while sleeping

○ Yes ○ No

2. Grinding his or her teeth

○ Yes ○ No

3. Wetting the bed

○ Yes ○ No

4. Having difficulty in school/learning

○ Yes ○ No

5. Being treated for ADD or ADHD

○ Yes ○ No

6. Breathing primarily through their mouth

○ Yes ○ No

7. Having frequent nightmares/night terrors

○ Yes ○ No

8. Having frequent earaches

○ Yes ○ No