

# DENTAL SLEEP QUESTIONNAIRE

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

## CURRENT THERAPIES

Have you attempted CPAP therapy? .....  YES NO

- If yes, are you able to use it at least 5 nights a week (4 or more hours per night)? .....  YES NO

Have you undergone any surgical attempts to correct your sleep apnea? .....  YES NO

Have you tried any of the following conservative methods of improving your sleep breathing? (Please check)

Weight loss

Positional therapy: Avoiding sleeping on your back during sleep (the supine position)

Abstaining from the use of alcohol and/or sedatives before bedtime

## SLEEP OBSERVATIONS (Also refer to physical evaluation form)

Do you snore loudly? .....  YES NO

Do you often feel tired or fatigued after sleep? .....  YES NO

Has anyone noticed that you stop breathing during sleep? .....  YES NO

Do you take medication for high blood pressure? .....  YES NO

## EPWORTH SLEEP SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 choose the most appropriate number for each situation. (Please circle the number to answer.)

	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading .....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Watching TV .....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Sitting inactive in a public place (e.g., a theater or a meeting) .....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
As a passenger in a car for an hour without a break .....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit ...	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Sitting and talking to someone .....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Sitting quietly after lunch without alcohol .....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
In a car while stopped for a few minutes in traffic .....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<b>TOTALS</b> .....	_____	_____	_____	_____