

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

First Name _____ Middle Name _____ Last Name _____

Do You Currently Use A CPAP Machine? Yes No If Yes, How Often _____

▲ If you answered yes, please skip the rest of the form, and sign your name at the bottom.

Weight _____ (in lbs.) Age _____ (in years) Date of Birth _____ / _____ / _____ (month) (day) (year) Gender: Male Female

Height _____ (in inches) Neck Size _____ (in inches)

**TALLY ALL
RISK POINTS**
(For Office Use Only)

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

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	<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 Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Medications (e.g. Vicodin, Oxycontin, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> 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.....	<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"/>

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?	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely (+1)	<input type="checkbox"/> Sometimes (+2)	<input type="checkbox"/> Frequently (+3)	<input type="checkbox"/> Almost Always (+4)
Do You Wake Up Choking or Gasping?	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely (+1)	<input type="checkbox"/> Sometimes (+2)	<input type="checkbox"/> Frequently (+3)	<input type="checkbox"/> Almost Always (+4)
Have You Been Told You Stop Breathing In Your Sleep or Wake Up Choking or Gasping?	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely (+1)	<input type="checkbox"/> Sometimes (+2)	<input type="checkbox"/> Frequently (+3)	<input type="checkbox"/> Almost Always (+4)
Do You Have Problems Keeping Your Legs Still At Night or Need To Move Them To Feel Comfortable?	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely (+1)	<input type="checkbox"/> Sometimes (+2)	<input type="checkbox"/> Frequently (+3)	<input type="checkbox"/> Almost Always (+4)

Assign Points For
Each Of The First
Three Responses

Score _____

Score _____

Score _____

Score _____

Sign Here Patient Signature (Parent or Guardian) _____ Date _____

FOR OFFICE USE ONLY

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.

If Point Totals = 4 or 5 (Low Risk)
6 or 10 (High Risk) and 11 or More
(Very High Risk)

TOTAL SCORE:

Dentist Signature

Date
