FAMILY DENTISTRY™
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SLEEP SCREENING EVALUATION

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)* / _____ *(BMI)* **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	☐ Yes	☐ No	**Stroke**	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	**Depression**	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	**Sleep Apnea**	☐ Yes	☐ No

Co-Morbidities
+1 For Each "Yes"

Score _____

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 Medications	☐ Yes	☐ No	**Pain Medications** *(e.g. Vicodin, Oxycontin, etc.)*	☐ Yes	☐ No

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 (+1)	☐ Sometimes (+2)	☐ Frequently (+3)	☐ 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 _____