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
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing</th>
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<tbody>
<tr>
<td>Sitting and reading</td>
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<tr>
<td>Watching TV</td>
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<tr>
<td>Sitting inactive in a public place (e.g. a theater or a meeting)</td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
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<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
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<tr>
<td>Sitting and talking to someone</td>
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<tr>
<td>Sitting quietly after lunch without alcohol</td>
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<tr>
<td>In a car while stopped for a few minutes in traffic</td>
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</tbody>
</table>

Total Score: ___________

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 (Coronary Artery Disease/Atherosclerosis) Yes □ No □
6. History of Stroke                                              Yes □ No □
7. Sleep Apnea
   If yes: Did you try to use CPAP                                 Yes □ No □
8. TMJ problems significant enough to require treatment           Yes □ No □
9. Gastric Reflux (GERD) 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 □
3. Clenching or grinding your teeth (bruxism)                      Yes □ No □
4. Having frequent headaches                                       Yes □ No □
5. Your neck size being > 17 inches (male) or > 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 ear aches                                      Yes □ No □

Dental Exam Findings:  □ Evidence of Bruxism  □ Scalloping of the tongue  □ Crowded airway  □ Tori or Bone Loss  □ Anterior wear  □ Retrognathia / Class II

New Patient/SSC Dental Sleep Screening Form NEW 1/2016