Hunterdon Family Dental Care
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Sleep Screening Form

Patient Name (PRINT) ____

Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:
(0=never, 1=slight, 2=moderate, 3=high chance of dozing) – CIRCLE ONE RESPONSE FOR EACH QUESTION

Sitting and reading………………………………………………….	0	1	2	3
Watching television………………………………………………….	0	1	2	3
Sitting in a public place………………………………………………..	0	1	2	3
As a passenger in a car for one hour………………………………..	0	1	2	3
Driving a car stopped for a few minutes in traffic…………………..	0	1	2	3
Sitting & talking to someone……………………………………….	0	1	2	3
Sitting down quietly after lunch without alcohol……………………	0	1	2	3
Lying down to rest in the afternoon………………………………….	0	1	2	3

Total Score: ______

Section 2: Patient Evaluation

	No(0)	Yes(1)
BMI (See Attached Chart): ______ Is it greater than or equal to 30?	0	1
Neck Circumference ______ Is it >17" (Men) or >15"(Women)?	0	1
Have you gained at least 15lbs in the past 6 months?	0	1

Total Score: ______

Section 3: Subjective Sleep Evaluation

	No(0)	Yes(1)
Do you snore?..	0	1
You, or your spouse, would consider your snoring louder than a person talking… .	0	1
Your snoring occurs almost every night………………………………………………..	0	1
Your snoring is bothersome to your bed partner…………………………………….......	0	1
Do you feel that in some way your sleep is not refreshing or restful?....................	0	1
Do you wake up at night or in the mornings with headaches?...............................	0	1
Do you experience fatigue during the day and have difficulty staying awake?.......	0	1
Do you have trouble remembering things or paying attention during the day?.......	0	1
Do you have high blood pressure?..	0	1

Total Score: ______

Section 4: Prior Diagnosis

	No(0)	Yes(1)
Have you previously been diagnosed with sleep apnea?	0	1

If Yes:
When were you diagnosed? (Approx mo/yr) _____________
Were you put on CPAP Therapy for treatment? _____________
Are you still using your CPAP every night? _____________

Notes: (Please insert any notes for the doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate use back of page if necessary.)

Section 5: Others

	No(0)	Yes(1)
Do you smoke?..	0	1
Do you have diabetes?	0	1
Do you grind/clench your teeth at night?	0	1
Do you drink alcohol before bed?	0	1

Patient Signature:___________________________________ **Date:** ____/____/____