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 Situation Chance of Dozing

Situation:	Chance of Dozing:
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (i.e. a theater or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch, without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____

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 Yes No If yes: Did you try to use CPAP Yes No
8. TMJ problems significant enough to require treatment Yes No
9. Gastric Reflux (GERO) 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 greater than 17 inches (male) or greater than 16 inches (female) Yes No
6. Anyone in your family having sleep apnea Yes No
7. Stopping breathing when sleeping/awakening with a gasp

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 earaches Yes No