Dental Practice Sleep Questionnaire

Name:	Gender: ☐ M ☐ F	DOB:	
Address:	Weight:	Height:	Neck Size:
Phone:	Alt. Phone:	Email:	
PPO Medical Insurance Company: (If no PPO, circle one: HMO, Medicare, No Ins.)	ID#:	Group#:	

Have you ever been diagnosed with a sleep disorder? ☐ Yes ☐ No	
Are you currently using a CPAP machine? ☐ Yes ☐ No	(If yes) Do you use it every night? ☐ Yes ☐ No

Answer ***"Yes"*** or ***"No"*** to the following questions (Circle Y or N):

Y	N	8	Have you ever been told you stop breathing while asleep?
Y	N	6	Have you ever fallen asleep or nodded off while driving?
Y	N	6	Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?
Y	N	4	Do you feel excessively sleepy during the day?
Y	N	4	Do you snore or have you ever been told that you snore?
Y	N	2	Have you had weight gain and found it difficult to lose?
Y	N	2	Have you taken medication for, or been diagnosed with high blood pressure?
Y	N	3	Do you kick or jerk your legs while sleeping?
Y	N	3	Do you feel burning, tingling or crawling sensations in your legs when you wake up?
Y	N	3	Do you wake up with headaches during the night or in the morning?
Y	N	4	Do you have trouble falling asleep?
Y	N	4	Do you have trouble staying asleep once you fall asleep?
0			**Score and Risk Factor** (**Add the points that you have circled "Y"**)

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

Rx: FOR OFFICE USE ONLY

- ☐ Enlarged/Scalloped Tongue
- ☐ Gastroesophageal Reflux
- ☐ Hypertension
- ☐ Retruded lower Jaw
- ☐ Enlarged Tonsils
- ☐ Heart Failure
- ☐ High Arching Hard Pallet
- ☐ Metabolic Syndrome
- ☐ Stroke
- ☐ Bruxism
- ☐ Diabetes
- ☐ Obesity

☐ Two-night Home Sleep Study or ____-night (Indicate number of days 1-3)
☐ Baseline ☐ Follow-up w/Appliance

☐ Consultation With Sleep Certified Physician
☐ CPAP Titration/Other__________________

Notes:

Dental Practice/Group:	**Dental Professional Name:**	
Physical Address:		
Phone:	**Fax:**	**Email:**
State Licence #:	**NPI #:**	
Dr. Signature:	**Date:**	**Office Contact:**

This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

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