Sleep Related Dental Questionnaire

Name: _____ Age: _____Gender: _____

Height: _____ ____ in. Weight:_____ lbs. Blood Pressure: _____ / _____mm Hg

AFib	Yes ☐	No ☐	Thyroid problems	Yes ☐	No ☐
Heart disease or failure	Yes ☐	No ☐	Head,neck or jaw pain	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Daytime tiredness	Yes ☐	No ☐
Weight gain	Yes ☐	No ☐	Chronic pain	Yes ☐	No ☐
CPAP use	Yes ☐	No ☐	Taken a sleep test	Yes ☐	No ☐
Difficulty staying asleep	Yes ☐	No ☐	High blood pressure	Yes ☐	No ☐
Family history of sleep apnea	Yes ☐	No ☐	Snore	Yes ☐	No ☐
Type 2 diabetes	Yes ☐	No ☐	Headaches	Yes ☐	No ☐
Acid reflux	Yes ☐	No ☐	Mornings feel great	Yes ☐	No ☐
Sleep apnea	Yes ☐	No ☐		Yes ☐	No ☐

Epworth Sleepiness Scale

How likely are you to feel tired or doze

Situation	**Chance of Dozing**			
Sitting and reading	No ☐	Slight ☐	Moderate ☐	High ☐
Watching TV	No ☐	Slight ☐	Moderate ☐	High ☐
Sitting inactive in a public place (e.g a theater or a meeting)	No ☐	Slight ☐	Moderate ☐	High ☐
As a passenger in a car for a hour without a break	No ☐	Slight ☐	Moderate ☐	High ☐
Lying down to rest in the afternoon when circumstances permit	No ☐	Slight ☐	Moderate ☐	High ☐
Sitting and talking to someone	No ☐	Slight ☐	Moderate ☐	High ☐
Sitting quietly after lunch without alcohol	No ☐	Slight ☐	Moderate ☐	High ☐
In a car, while stopped for a few minutes in traffic	No ☐	Slight ☐	Moderate ☐	High ☐