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**
1. Sitting and reading	____
2. Watching TV	____
3. Sitting inactive in a public place (e.g. 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 when circumstances permit	____
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:	**Yes**	**No**
1. Impaired Cognition (i.e. difficulty concentrating or thinking)	☐	☐
2. Mood Disorders/Depression	☐	☐
3. Insomnia	☐	☐
4. Hypertension (high blood pressure)	☐	☐
5. Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	☐	☐
6. History of Stroke	☐	☐
7. Sleep Apnea	☐	☐
If yes: Did you try to use CPAP	☐	☐
8. TMJ problems significant enough to require treatment	☐	☐
9. Gastric Reflux (GERD) or Heartburn	☐	☐

Are you aware of (or have you been told):	**Yes**	**No**
1. Snoring on a regular basis	☐	☐
2. Feeling tired or fatigued on a regular basis	☐	☐
3. Clenching or grinding your teeth (bruxism)	☐	☐
4. Having frequent headaches	☐	☐
5. Your neck size being > 17 inches (male) or > 16 inches (female)	☐	☐
6. Anyone in your family having sleep apnea	☐	☐
7. Stopping breathing when sleeping/awakening with a gasp	☐	☐

For children only (filled out by parent or guardian)

Are you aware of your child:	**Yes**	**No**
1. Snoring/noisy breathing while sleeping	☐	☐
2. Grinding his or her teeth	☐	☐
3. Wetting the bed	☐	☐
4. Having difficulty in school/learning	☐	☐
5. Being treated for ADD or ADHD	☐	☐
6. Breathing primarily through their mouth	☐	☐
7. Having frequent nightmares/night terrors	☐	☐
8. Having frequent ear aches	☐	☐

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

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