SLEEP QUESTIONNAIRE

DATE: _____

PATIENT NAME: _____

Height: _____ Weight:_____ ☐ Male ☐ Female

WIMBERLEY
DENTAL & WELLNESS

FOR OFFICE USE ONLY	
703 x $\frac{weight\ (lbs)}{height^2(in^2)}$= BMI	BMI: BMI more than 30? ☐ NO☐ YES
Neck size (measuring around the adam's apple)	
Males: inches	17 in./42cm or larger ☐ NO☐ YES
Females: inches	16 in./41cm or larger ☐ NO☐ YES

PLEASE ANSWER NO OR YES TO THE FOLLOWING QUESTIONS:		
Have you ever been diagnosed with Sleep Apnea?	☐ NO	☐ YES
Have you ever had/used a CPAP machine?	☐ NO	☐ YES
Have you ever participated in a sleep study? Date of your sleep study:	☐ NO	☐ YES

Do you think you get enough sleep at night? How many hours:	☐ NO	☐ YES
Do you or have you been told you snore? Would you say: ☐ MILD ☐ MODERATE ☐ SEVERE	☐ NO	☐ YES
Has anyone observed you stop breathing or choking/gasping during your sleep?	☐ NO	☐ YES
Have you ever awaken yourself with a snort, choking/gasping for air?	☐ NO	☐ YES
Do you have trouble falling asleep?	☐ NO	☐ YES
Do you have trouble staying asleep throughout the night?	☐ NO	☐ YES
Do you often wake in the morning with a headache?	☐ NO	☐ YES
Do you often feel tired, fatigued, or sleepy during the daytime?	☐ NO	☐ YES
Do you take naps during the day? If so, how long?_____	☐ NO	☐ YES
Do you awaken with acid or sour taste in your mouth?	☐ NO	☐ YES
Do you have acid reflux or wake with heartburn at night or in the morning?	☐ NO	☐ YES
Do you sometimes feel you have a lump in your throat?	☐ NO	☐ YES

Have you ever broken your nose?	☐ NO	☐ YES
Have you ever had sinus or nasal surgery? TYPE:	☐ NO	☐ YES
Have you ever been told you have a deviated septum?	☐ NO	☐ YES
Have you had any type of head or neck injury? EXPLAIN:	☐ NO	☐ YES
Have you had your tonsils or adenoids removed?	☐ NO	☐ YES

Do you experience restless legs, repetitive limb jerks or night sweats?	☐ NO	☐ YES
Do you have or have you been diagnosed with high blood pressure?	☐ NO	☐ YES
Do you have or have you been diagnosed with heart problems (other than high blood pressure)?	☐ NO	☐ YES
Do you have type 2 diabetes or other blood sugar problems?	☐ NO	☐ YES
Do you have to urinate several times during the night or males, have you been diagnosed with BPH?	☐ NO	☐ YES
Do you have any pulmonary conditions such as COPD, Asthma or Chronic Bronchitis?	☐ NO	☐ YES
Have you had surgery to promote weight loss? TYPE:	☐ NO	☐ YES

EPSWORTH SLEEPINESS SCALE

PLEASE INDICATE HOW LIKELY YOU ARE TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS. CIRCLE ONE RESPONSE FOR EACH QUESTION:

0 = NEVER 1 = SLIGHT 2 = MODERATE 3 = HIGH CHANCE OF DOZING OFF

SITTING AND READING	0	1	2	3
WATCHING TELEVISION	0	1	2	3
SITTING INACTIVE IN A PUBLIC PLACE (e.g. theater, meeting)	0	1	2	3
AS A PASSANGER IN A CAR FOR ONE HOUR WITHOUT A BREAK	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
SITTING OR TALKING TO SOMEONE	0	1	2	3
IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC	0	1	2	3

MY TOTAL SCORE: _____

PATIENT/GUARDIAN SIGNATURE:_____