

# Matthews Family Dentistry

## Initial Patient Sleep Screening Form

Patient Name (PRINT) \_\_\_\_\_

### Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:

(0=never, 1=slight, 2=moderate, 3=high chance of dozing)- **CIRCLE ONE RESPONSE FOR EACH QUESTION**

Sitting and reading.....	0	1	2	3
Watching television.....	0	1	2	3
Sitting in a public place.....	0	1	2	3
As a passenger in a car for one hour.....	0	1	2	3
Driving a car stopped for a few minutes in traffic.....	0	1	2	3
Sitting and talking to someone.....	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

Total Score: \_\_\_\_\_

### Section 2: Patient Evaluation

Fill in the blanks, circle on yes or no response for each question

	No (0)	Yes (1)
BMI (See attached chart): _____ Is it greater than or equal to 30?	0	1
Neck Circumference _____ Is it >17" (Men) or >15" (Women)?	0	1
Have you gained at least 15 pounds in the past 6 months?	0	1

Total Score: \_\_\_\_\_

### Section 3: Subjective Sleep Evaluation

Please circle one yes or no response for each question

	No (0)	Yes (1)
Do you snore?.....	0	1
You, or your spouse, would consider your snoring louder than a person talking.....	0	1
Your snoring occurs almost every night.....	0	1
Your snoring is bothersome to your bed partner?.....	0	1
Do you feel that in some way your sleep is not refreshing or restful?.....	0	1
Do you wake up at night or in the mornings with headaches?.....	0	1
Do you experience fatigue during the day and have difficulty staying awake?.....	0	1
Do you have trouble remembering things or paying attention during the day?.....	0	1
Do you have high blood pressure?.....	0	1

Total Score: \_\_\_\_\_

### Section 4: Prior Diagnosis

	No (0)	Yes (1)
Have you previously been diagnosed with sleep apnea?.....	0	1

If Yes:

When were you diagnosed? (Approx mo/yr) \_\_\_\_\_

Were you put on CPAP Therapy for treatment? \_\_\_\_\_

Are you still using your CPAP every night? \_\_\_\_\_

Total Score: \_\_\_\_\_

Notes: (Please insert any notes for doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate use back of page if necessary.)

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### OFFICE USE ONLY

Advance Screening Criteria, if yes to any below patient should be scheduled for advanced OSA screening.

\_\_\_\_ ESS Score >8?    \_\_\_\_ Pt. Eval >2?    \_\_\_\_ Subjective Sleep Eval >3?    \_\_\_\_ Prior OSA Dx > 1?