Initial Patient APNEA / Sleep Screening NAME(Please Print):_____

Apnea is a serious medical condition that can contribute to overall health issues; it literally means 'absence of breath'. It can contribute to medical issues such as hypertension (high blood pressure), heart disease, diabetes and depression. It affects quality of sleep which can lead to additional issues such headaches, memory issues and daytime sleepiness which can have other unforeseen consequences. Please complete the 1st section of the screening and follow the appropriate steps below.

Step 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 TV	0	1	2	3	
Sitting inactive in a public place	0	1	2	3	
A passenger in a car for an hour without a break	0	1	2	3	
Driving a car....stopped for a few minutes in traffic	0	1	2	3	
Lying down to rest in the afternoon	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch (without alcohol)	0	1	2	3	Total = _____

If your total is 0 - 9 **STOP** here. If your score is 10 or greater, please complete the following:

Step 2. SUBJECTIVE SLEEP EVALUATION

Do you snore?	YES	NO
Your snoring occurs almost every night?	YES	NO
Your snoring is bothersome / disrupting to a bed partner?	YES	NO
You have been told you stop breathing or gasp for breath?	YES	NO
Do you feel your sleep is not refreshing or restful?	YES	NO
Do you wake up at night or in the mornings with headaches?	YES	NO
Are you excessively tired during the day / trouble staying awake?	YES	NO
Do you have trouble remembering things / paying attention?	YES	NO

If you answered YES to 2 or more of the above questions, please answer the following questions:

Step 3. RELATED HEALTH HISTORY

Do you have a history of or ever been diagnosed with any of the following?

Loud Snoring	YES	NO
Hypertension (High Blood Pressure)	YES	NO
Heart Disease	YES	NO
Diabetes	YES	NO
Depression	YES	NO
Thyroid Disease	YES	NO
Stroke	YES	NO
COPD (Chronic Obstructive Pulmonary Disease)	YES	NO
Restless Leg Syndrome	YES	NO
Insomnia	YES	NO
Night Time Urination	YES	NO

CONTINUED ON THE BACK

Step 3 cont. RELATED HEALTH HISTORY CONT.

Have you ever had a sleep study or taken a sleep test?	YES	NO
If YES; When?_____		
Have you ever been diagnosed with Sleep Apnea?	YES	NO
If YES; When?_____		
Have you been prescribed a CPAP machine?	YES	NO
If YES; Did you use your CPAP machine as prescribed?	YES	NO
Are you interested in an Oral Appliance to treat your sleep apnea?	YES	NO

If you answered YES to the previous question proceed to Step 4 and then complete Step 5.

Step 4. OBJECTIVE SLEEP EVALUATION
(Observations by a bed partner)

Please circle the appropriate answer for the following if you are aware, have been observed or told you do or have any of the following conditions:

Snoring	Never	Rarely	Occasionally	Nightly
Observed pauses in breathing	Never	Rarely	Occasionally	Nightly
Restless or interrupted sleep	Never	Rarely	Occasionally	Nightly
Awaken short of breath	Never	Rarely	Occasionally	Nightly
Gasping for breath / snorting	Never	Rarely	Occasionally	Nightly
Awaken coughing	Never	Rarely	Occasionally	Nightly
Difficulty falling asleep	Never	Rarely	Occasionally	Nightly
Leg or body jerks	Never	Rarely	Occasionally	Nightly
Teeth grinding	Never	Rarely	Occasionally	Nightly
Vivid dreams	Never	Rarely	Occasionally	Nightly
Headache	Never	Rarely	Occasionally	Nightly
Acid indigestion	Never	Rarely	Occasionally	Nightly
Night sweats	Never	Rarely	Occasionally	Nightly
Heart palpitations	Never	Rarely	Occasionally	Nightly
Night time urination	Never	Rarely	Occasionally	Nightly
Refreshed with morning wake up	Never	Rarely	Occasionally	Nightly
Dry mouth with morning wake up	Never	Rarely	Occasionally	Nightly
Sore jaw with morning wake up	Never	Rarely	Occasionally	Nightly

Step 5. PERSONAL INFORMATION

Gender: M F Height:_____ Weight:_____

Neck size (if known)_____ DOB:_____ BMI (body mass index)_____

Medical Insurance Company:_____ Phone #_____

Group Name:_____ Group Number:_____ Subscriber/Member ID#_____

General Dentist ? Yes No If Yes; Name: _____

Dental Insurance? Yes No If Yes; Company: _____