SIOUXLAND sleep solutions
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Sleep Health – 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 + overall health. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth + sleep disorders. Sleep apnea may increase your risk for many different health conditions including heart attach 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: _____

DOB: _____ Age: _____ Male or Female: _____

Epworth Sleepiness Scare (ESS)

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. While sitting or reading?	_____
2. Watching TV?	_____
3. Sitting inactive in a public place (theater or meeting)?	_____
4. As a passenger in a car for an hour without a break?	_____
5. Lying down to rest in the afternoon when possible?	_____
6. Sitting and talking to someone?	_____
7. Sitting quietly after a lunch without alcohol?	_____
8. In a car while stopped for a few minutes at a traffic light?	_____

Total Score _____

Have you ever been diagnosed with:	YES	NO	Not Sure
1. Impaired Cognition (i.e., difficulty concentrating or thinking)	☐	☐	☐
2. Mood Disorders	☐	☐	☐
3. Insomnia	☐	☐	☐
4. Hypertension (high blood pressure)	☐	☐	☐
5. Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	☐	☐	☐
6. History of Stroke	☐	☐	☐
7. Obstructive Sleep Apnea (OSA), If yes did you try to use a CPAP	☐	☐	☐
8. Gastric Reflux (GERD) or Heartburn	☐	☐	☐

Are you aware of (or have you been told):	YES	NO	Not Sure
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 (female)	☐	☐	☐
6. Anyone in your family having sleep apnea (OSA)	☐	☐	☐
7. Stopping breathing when sleeping/awakening with a gasp	☐	☐	☐

Are you aware of your child: (for children only, filled out by parent/guardian)	YES	NO	Not Sure
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/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

CLEAR FORM