Surf City Dentist
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SLEEP EVALUATION

Todays Date _____

Name _____

Date of Birth _____ Gender: M____ F____ Height:_____ Weight:_____

Please check any of the following you may have:		
☐ Diabetes	☐ Bruxims (teeth grinding)	☐ Erectile Dysfunction
☐ Stroke	☐ Obese (BMI >30)	☐ Frequent Urination at Night
☐ Depression	☐ Hypertension (High Blood Pressure)	☐ Morning Headaches
☐ Gerd (Acid Reflux)	☐ Snoring	☐ Waking, Choking, Gasping for Air

Please check YES of NO to the following questions:		
1. Do you snore or have you been told that you snore?	☐ YES	☐ NO
2. Do you often feel tired, fatigued, or sleepy during the daytime?	☐ YES	☐ NO
3. Has anyone observed you stop breathing or gasp for air during your sleep?	☐ YES	☐ NO
4. Do you have or are you being treated for high blood pressure?	☐ YES	☐ NO

If you answered YES to 2 or more of the above, please continue:

Epworth Sleepiness Scale	Never Doze Off	Slight Chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
How likely are you to get sleepy or doze off during the following activities:				
1. While sitting and reading?	☐ 0	☐ 1	☐ 2	☐ 3
2. While watching TV?	☐ 0	☐ 1	☐ 2	☐ 3
3. While sitting inactive in a public place?	☐ 0	☐ 1	☐ 2	☐ 3
4. As a passenger in a car for an hour without a break?	☐ 0	☐ 1	☐ 2	☐ 3
5. Lying down to rest in the afternoon?	☐ 0	☐ 1	☐ 2	☐ 3
6. Sitting and talking to someone?	☐ 0	☐ 1	☐ 2	☐ 3
7. Sitting quietly after lunch without alcohol?	☐ 0	☐ 1	☐ 2	☐ 3
8. In a car while stopped for a few minutes at a traffic light?	☐ 0	☐ 1	☐ 2	☐ 3

Total Score: ____

0-5 = Normal Daytime Sleepiness
6-10 = Higher Normal Daytime Sleepiness
11-15 = Mild to Moderate Risk
16-Higher = Severe Risk

Have you ever been diagnosed with Sleep Apnea?	☐ YES	☐ NO
Are you currently using CPAP (or any other apnea/snoring device)?	☐ YES	☐ NO
Are you currently taking any sleeping aids (prescribed or OTC)?	☐ YES	☐ NO
Are you aware of clenching or grinding your teeth?	☐ YES	☐ NO

Patient/Guardian Signature _____ Date _____

Comments:

Provider Signature _____ Date _____