Ron M. Ask, D.D.S.
Craig A. Kinzer, D.D.S.
Dwight D. Simpson, D.D.S.
Leon Roda III, D.D.S.
Jerhet R. Ask, D.D.S.

Sleep Apnea Screener

Sleep disorders have recently been noted to be a major cause of a variety of dental and medical problems. These problems include bruxism, clenching, tooth erosion, headaches, fatigue, TMJ problems, hypertension, heart disease, strokes, diabetes and gastric reflux. Sleep disorders have become an epidemic in our society due to allergies and weight gain. Research has shown that 50% of men and 30% of women suffer from sleep disorders in a typical practice.

Because our practice is committed to your total health care, we have added sleep disorder dentistry to our practice. Please fill out the following sleep disorder questionnaire so that we may completely evaluate your health.

First Name: **Middle Initial:** **Last Name:**

1. On average in the past month, how often have you snored or been told you snore?

O Never O Rarely (>1/week) O Sometimes (1-2/week) O Frequently (3-4/week) O Almost Always (5-7/week)

Date of Birth: **Age:** O **Male** O **Female** **Neck Circumference- Inches:**

Height- Feet: **Inches:** **Weight:** **BMI:**

Have you been diagnosed or treated for any of the following conditions?

Condition			Condition		
High Blood Pressure	O Yes	O No	Depression	O Yes	O No
Heart Disease	O Yes	O No	Gastric Reflux	O Yes	O No
Diabetes	O Yes	O No	Sleep Apnea	O Yes	O No
Stroke	O Yes	O No	C-PAP	O Yes	O No

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they have affected you. Use the following scale to check the most appropriate number for each situation. 0=never doze 1=slight chance of dozing 2=moderate chance of dozing 3=high chance of dozing

	0	1	2	3
Sitting and reading	O	O	O	O
Watching TV	O	O	O	O
Sitting, inactive, in a public place (theater, meeting, etc.)	O	O	O	O
As a passenger in a car for an hour without a break	O	O	O	O
Lying down to rest in the afternoon when circumstances permit	O	O	O	O
Sitting and talking to someone	O	O	O	O
Sitting quietly after lunch without alcohol	O	O	O	O
In a car, while stopped for a few minutes in traffic	O	O	O	O

Score:_______

2. Do you wake up choking or gasping?

O Never O Rarely (>1/week) O Sometimes (1-2/week) O Frequently (3-4/week) O Almost Always (5-7/week)

3. Have you been told that you stop breathing in your sleep or wake up choking or gasping?

O Never O Rarely (>1/week) O Sometimes (1-2/week) O Frequently (3-4/week) O Almost Always (5-7/week)

FOR OFFICE USE ONLY

O You have a very Low or No Apparent risk of having a sleep disorder and we will review this annually.

O You have greater that a 50% probability of having a sleep disorder and we recommend a complimentary home sleep study.

Scoring: **1** (Snoring + >17men, >16 women; BMI >30; any one condition; Epworth >6) or **2-3** (Observed gasping or choking) = positive result.

Patient Signature:____ Date: ______________

Staff Member:____ Date: ______________

Dr. of record:_______