EPWORTH SLEEP QUESTIONNAIRE

Using the following scale, choose the most appropriate number for each situation.
0= No chance of dozing
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Sitting and reading _______
Watching TV __________
Sitting inactive in a public place (e.g. theater or meeting) ________
As a passenger in a car for an hour without a break __________
Lying down to rest in the afternoon when circumstances permit ____
Sitting and talking to someone ________
Sitting quietly after lunch without alcohol _____________
In a car, while stopped for a few minutes in traffic _________

THORNTON SNORING SCALE

Using the following scale, choose the most appropriate number for each situation.
0=Never
1= Infrequently (1 night per week)
2=Frequently (2-3 times per week)
3= Most of the time (4 or more nights)

My snoring affects my relationship with my partner ______
My snoring causes my partner to be irritable or quiet ______
My snoring requires us to sleep in separate rooms______
My snoring is loud ________
My snoring affects people when I am sleeping away from home ____

BASELINE SLEEP SYMPTOMS

What is the main reason you are seeing treatment? ______________________

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Other Complaints
Please check other complaints below:
- o Frequent snoring
- o Excessive daytime sleepiness
- o Waking up gasping
- o Nighttime heartburn or GERD
- o Morning headaches
- o Clenching or grinding teeth in the night
- o Neck or facial pain
- o I have been told that I stop breathing when I sleep
- o Irritability or mood swings
- o Snoring which affects the sleep of others
- o Others have observed that I stop breathing while I sleep
- o Difficulty in maintaining sleep
- o Choking in my sleep
- o Feeling unrefreshed in the morning
- o Nasal problems or difficulty breathing through the nose
- o TMJ or jaw pain
- o Sounds in jaw joint (clicking, popping or grating)
- o Memory problems
- o Other

Rate your energy level 0-10 (10 being the highest) ______
Rate your sleep quality 0-10 (10 being the highest)______
Have you been told you snore ? Sometimes____Often____Always____
Rate the sound of your snoring 0-10 (10 being the highest)
On average how many times per night do you wake up?_____
On average how many hours of sleep do you get per night? _____
Do you have morning headaches? Sometimes____Often___Always___
Do you have a bed partner?
If yes, do they sleep in the same bed?
Sometimes___Often___Always___
How many times per night does your bedtime partner notice you quit breathing? _________

MEDICAL HISTORY

Premedication

Have you been told you should receive pre-medication prior to dental procedures Yes_____No_____

Allergens

Do you have any known allergens (for example: aspirin, latex, penicillin, etc.?) Yes_____No_______

Current Medications :

Please list all medications you are currently taking:

____

____

____

Medical History

Please list all medical diagnoses and surgeries that you have received. (for example, heart attack, high blood pressure, asthma, stroke, HIV, diabetes, mood disorder, etc.)

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Dental History

How would you describe your dental health?
Excellent_____Good____Fair_____Poor______
Have you ever had teeth removed? Yes______No_________
Do you wear removable partial dentures? Yes_____No_______
Do you wear full dentures on one or both arches of your mouth?
Yes____No______
Have you had orthodontic treatment? Yes________No________
Does your TMJ (jaw joint) click or pop? Yes______No_________
Have you ever had gum problems? Yes________No_______
Do you have morning dry mouth? Yes______No_________

Have you ever had injury to your head, face, neck, mouth or teeth?
Yes______No_____
Are you planning any dental treatment in the near future (besides routine maintenance)? Yes______No_______

Family History

Have genetic members of your family had:
Heart disease? Yes___No___
High blood pressure? Yes______No_____
Diabetes? Yes_______No____
Sleep apnea, snoring or other sleep disorders? Yes_____No_____

Social History

Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?
Daily________Occasionally_________Never_______
Sedative Consumption : How often do you take sedatives within 2-3 hours of bedtime?
Daily_________Occasionally_________Never_______
Caffeine Consumption: How often do you consume caffeine within 2-3 hours of bedtime?
Daily_________Occasionally_________Never_________
Do you smoke? Yes____No______
If yes, number of pack per day _________
Do you chew tobacco? Yes_______No____

Sleep Studies

Have you had a sleep study? Yes________No_______
If yes, where_____________________________Date____________________

CPAP intolerance

Have you tried CPAP? Yes________No________

Dental Devices

Are you currently wearing a dental device designated to treat sleep apnea or snoring? Yes_____No_________
Have you previously tried a dental device for sleep apnea treatment?
Yes_____No_______

Surgery

Have you had surgery for snoring or sleep apnea?
Yes______No______

Other Attempted Therapies

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