POINT PLACE DENTAL
we love to see you smile

Sleep Questionnaire

Your Name: _____ **Age:** _____ **Date of Birth** _____

Weight _____ **Height** _____

Please check the following questions that apply to you:

- ❒ Do you snore? ❒ Mild ❒ Moderate ❒ Severe? How many years? ___
- ❒ Do you snore: ❒ On your side? ❒ on your back?
  Usual position:❒ back ❒ side ❒ stomach
- ❒ Do you fall asleep when reading, watching TV, or other passive activities?
- ❒ Do you fight sleepiness on the job or when driving?
- ❒ Do you most often wake with headaches?
- ❒ Do you wake up with a sore throat?
- ❒ Do you ever wake choking or gasping for air?
- ❒ Do you most often wake up feeling tired, fatigued, and unrefreshed?
- ❒ Do you take naps during the day? If so, for how long? ____
- ❒ Do you have trouble *falling* asleep? On average, how long to go to sleep? _____
- ❒ Do you have trouble *staying* asleep throughout the night?
  Number of times you wake up at night ___
  Length of time getting back to sleep after you wake up at night ___
- ❒ Do you have restless or "creepy, crawly" leg feelings?
- ❒ Do you experience unusual behaviors just before, during or after sleep?
- ❒ Do you ever wake up feeling *paralyzed*?
- ❒ Have you ever experienced a sudden loss of strength in your arms/legs during the day?
- ❒ Do you feel unhappy or discouraged about your sleep?
- ❒ Do you have trouble concentrating during the day?
- ❒ Do you have trouble with forgetfulness or with your memory?
- ❒ Does your sleep problem affect your family life, work performance?
- ❒ How many caffeinated beverages do you have each day? _____
- ❒ Do you think you get enough sleep at night? Number of hours of sleep per night ____

Does your bed partner complain of:

- ❒ You are a loud snoring?
- ❒ Your partner sometimes sleeps in another room at night because of your snoring?
- ❒ Your twitching legs, kicking or excessive moving at night?
- ❒ Long breathing pauses during your sleep?

Do you have or ever had the following:

- ❒ Jaw popping, clicking or grinding?
- ❒ Your jaw ever locked or gotten stuck?
- ❒ Been told you grind your teeth at night (brux)?
- ❒ Ever had a mouth guard made by a Dentist?

Rank how likely it would be for you to become drowsy during the day in the following situations:

0= Would never doze
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Epworth Sleepiness Scale

Situation	Chance of dozing
Sitting & Reading	
Watching TV	
Sitting inactive in a public place (i.e. theater)	
As a car passenger for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, stopped for a few minutes in traffic	
Total score:	

My sleep problems are:

Sleep Medications taken in the last year: (includes nonprescription)

_____

Have you ever had other treatments for sleep apnea? _____

Why did you stop that treatment? _____

Do you:

- ❒ have high blood pressure?
- ❒ have any heart problems?
- ❒ have type 2 diabetes or any other blood sugar issues?
- ❒ have acid reflux or wake with heart burn at night or in the morning?
- ❒ feel as though you are over your healthy weight?

Have you ever had a sleep study? ❒ Yes ❒ No
If YES, then please have the sleep lab fax results to: 715.544.1335. Thank you.

Patient Signature: _____ Date: _____