Sleep Screening Questionnaire

Please answer the questions below to help us assess the possibility of a sleep disorder. There is often a correlation between TMJ disorders and sleep disorders. Sleep apnea can increase your risk for many health conditions.

Patient Name: _____ Height: _____ Weight: _____

Epworth Sleepiness Scale

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. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theatre or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____
Total Score	_____

		Yes	**No**	**Not Sure**
1.	Have you been told (or noticed on your own) that you snore most nights?	☐	☐	☐
2.	Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep, sometimes followed by a GASP?	☐	☐	☐
3.	Are you tired, fatigued or sleepy on most days?	☐	☐	☐
4.	Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions)?	☐	☐	☐
5.	Are you overweight?	☐	☐	☐
6.	Have you ever been diagnosed with obstructive sleep apnea (OSA)?	☐	☐	☐
7.	Are you currently being treated for OSA?	☐	☐	☐
8.	Are you aware of family history of OSA?	☐	☐	☐
9.	Are you aware of clenching or grinding your teeth at night?	☐	☐	☐
10.	Do you snore loudly (louder than talking or loud enough to be heard behind a closed door)?	☐	☐	☐
11.	Do you often feel tired, fatigued or sleepy during the daytime?	☐	☐	☐
12.	Has anyone observed you stop breathing during your sleep?	☐	☐	☐
13.	Do you have, or are you being treated for high blood pressure?	☐	☐	☐
14.	Are you 50 years old or older?	☐	☐	☐
15.	Does your neck measure more than 15 ¾ inches (40cm) around?	☐	☐	☐
16.	Are you a male?	☐	☐	☐
17.	Do you weigh more for your height than is shown in the table below?	☐	☐	☐

Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)
4’10”	167	5’3”	197	5’8”	230	6’1”	265
4’11”	173	5’4”	204	5’9”	237	6’2”	272
5’	179	5’5”	210	5’10”	243	6’3”	279
5’1”	185	5’6”	216	5’11”	250	6’4”	287
5’2”	191	5’7”	223	6’	258	6’5”	295
Weights shown in the tables above correspond to BMI of 35 for a given height.							