# 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. | | | | | | | |