***GENERAL, COSMETIC, IMPLANT AND***

***SLEEP DENTISTRY***

**SLEEP HEALTH QUESTIONNAIRE**

Patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Completely answer all the questions*

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

High blood pressure Yes \_\_ No\_\_ Stroke Yes\_\_ No\_\_

Heart Disease Yes\_\_ No\_\_ Depression Yes\_\_ No\_\_

Diabetes Yes\_\_ No\_\_ Sleep apnea Yes\_\_ No\_\_

Insomnia Yes\_\_ No\_\_ Narcolepsy Yes\_\_ No\_\_

Acid reflux Yes\_\_ No\_\_ Unrefreshed sleep Yes\_\_ No\_\_

***Epworth Sleepiness Scale*:** How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Circle the number that applies. Please answer all the questions.

**0**= Would never doze  **1**=Slight chance of dozing

**2**=Moderate chance **3**=High chanvce of dosing

Sitting and reading 0 1 2 3

Watching TV 0 1 2 3

Sitting inactive in a public place { Theater, meeting, etc} 0 1 2 3

As a passanger in a car without a break 0 1 2 3

Lying down to rest in the afternoon when circumstance permit 0 1 2 3

Sitting and talking to someone 0 1 2 3

Sitting quietly after lunch without alcohol 0 1 2 3

In a car, while stopped for few minutes in traffic 0 1 2 3

***Section 2:Patient evaluation***- Circle yes or no

Do you dream? Yes No

Do you wake up with morning headaches? Yes No

Do you wear a night guard? Yes No

***Section 3: Patient evaluation***

**On average in the past month, how often have you snored or told that you snored?**

Never\_\_\_ Rarely\_\_\_ Sometimes\_\_\_ Frequently\_\_\_ Almost always\_\_\_

**Do you wake up chocking or gasping?**

Never\_\_\_ Rarely\_\_\_ Sometimes\_\_\_ Frequently\_\_\_ Almost always\_\_\_

**Have you been told that you stop breathing in your sleep or wake up chocking or gasping?**

Never\_\_\_ Rarely\_\_\_ Sometimes\_\_\_ Frequently\_\_\_ Almost always\_\_\_

**Do you have problem keeping your legs still at night or need to move them to feel comfortable?**

Never\_\_\_ Rarely\_\_\_ Sometimes\_\_\_ Frequently\_\_\_ Almost always\_\_\_

Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_