Sleep Health Questionnaire

Name:			Gender: ☐M ☐F	DOB:
Address:	City:	State: Zip:	Weight:	Height: Neck Size:
Phone:	Alt. Phone:		Email:	
PPO Medical Insurance Company: (PPO Only)	ID#:		Group#:	

Have you ever been diagnosed with a sleep disorder? ☐ Yes ☐ No

Are you currently using a CPAP machine? ☐ Yes ☐ No If yes, do you use it every night? ☐ Yes ☐No

Answer '**Yes**' or '**No**' to the following questions (Circle Y or N):

Have you ever been told you stop breathing while asleep	Y	N	8
Have you ever fallen asleep or nodded off while driving?	Y	N	6
Have you woken up suddenly with shortness of breath, gasping, or heart racing?	Y	N	6
Do you feel excessively sleepy during the day?	Y	N	4
Do you snore or have you ever been told that you snore?	Y	N	4
Have you had weight gain and found it difficult to lose?	Y	N	2
Have you taken medication for, or diagnosed with high blood pressure?	Y	N	2
Do you kick or jerk your legs while sleeping?	Y	N	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y	N	3
Do you wake up with headaches during the night or in the morning?	Y	N	3
Do you have trouble falling asleep?	Y	N	4
Do you have trouble staying asleep once you fall asleep?	Y	N	4
Score and Risk Level-On right, add total pts you circled 'Y'			_____

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

FOR OFFICE USE ONLY

RX:

☐ Enlarged/Scalloped tongue
☐ Gastroesophageal Reflux
☐ Obstructive Sleep Apnea
☐ Retruded lower jaw
☐ Enlarged tonsils
☐ Sleep related Bruxism
☐ High arching hard pallet
☐ Metabolic Syndrome
☐ Stroke
☐ Hypertension
☐ Diabetes
☐ Obesity

☐ 2-night home sleep study or ___-night ☐ Consultation with primary care physician

☐ Baseline ☐ Follow-up w/appliance ☐ APAP therapy ☐ CPAP titration/other_____

Notes:

Dental Health Center		**Daniel Tebbi D.M.D.**
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Dr. Signature:	**Date:**	**Office Contact:**