

Sleep Screening Questionnaire

Name _____ Date _____ DOB _____

Height _____ Weight _____ BMI _____ Collar size/Neck circumference _____

	Yes	No
Have you ever been diagnosed with obstructive sleep apnea (OSA)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently being treated for OSA?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of a family history of OSA?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of clenching or grinding your teeth at night?	<input type="checkbox"/>	<input type="checkbox"/>

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

2 = I have a moderate chance of dozing

1 = I have a slight 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 in a lunch without alcohol | _____ |
| 8. In a car while stopped for a few minutes in traffic | _____ |

STOP - BANG

		Yes	No
1. Snore	Do you snore loudly? (Louder than talking or loud enough to be heard behind a closed door?)	<input type="checkbox"/>	<input type="checkbox"/>
2. Tired	Do you often feel tired, fatigued or sleepy during daytime?	<input type="checkbox"/>	<input type="checkbox"/>
3. Obstruction	Has anyone observed you stop breathing during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
4. Pressure	Do you have or are you being treated for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
5. BMI	Is your body mass index greater than 28?	<input type="checkbox"/>	<input type="checkbox"/>
6. Age	Are you 50 years old or older?	<input type="checkbox"/>	<input type="checkbox"/>
7. Neck	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	<input type="checkbox"/>	<input type="checkbox"/>
8. Gender	Are you a male?	<input type="checkbox"/>	<input type="checkbox"/>

- Class 0 - No Bruxism/Clenching
- Class I – mild bruxism defined as visual exam showing minor teeth wear or 1-2 bruxism bursts per sleep hour
- Class II – moderate bruxism defined as visual exam showing moderate teeth wear or 3-4 bruxism bursts per sleep hour
- Class III – severe bruxism defined as visual exam showing teeth wear or 5+ bruxism bursts per sleep hour

Provided by:

