# Sleep Health Questionnaire

GREEN VALLEY DENTISTRY
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☐ M ☐ F

Name | Gender | DOB

Address, City, State, Zip | Weight | Height

Cell Phone | Alt. Phone | Email

PPO Medical Insurance Company (PPO Only) | ID# | Group#

## Section 1 - Patient Sleepiness Scale:

Step 1: Answer "Yes" or "No" for the following questions (circle "Y" or "N"). If you answer "yes" also circle the corresponding points in the column to the right.

Step 2: Total the points that you circled in the right column and record score in the space below.

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

| Risk Level | Low | Moderate | High | Severe |
|---|---|---|---|---|
| **Score** | 0-7 | 8-11 | 12-15 | 16+ |

**Section 2 - Signs & Symptoms** (Check all that apply):

☐ Hypertension ☐ Snoring ☐ Diabetes ☐ Depression ☐ Grind Teeth

☐ Acid Reflux ☐ Stroke/Heart Disease ☐ Unrefreshed Sleep

☐ Family History of Snoring or Sleep Apnea

**Section 3 - Sleep History** (Check all that apply):

| | | |
|---|---|---|
| Have you ever been diagnosed with a sleep disorder? | ☐ Yes | ☐ No |
| Are you currently using a CPAP machine? | ☐ Yes | ☐ No |
| Do you use your CPAP less than 5 times a week? | ☐ Yes | ☐ No |
| Would you prefer and oral appliance? | ☐ Yes | ☐ No |

Please Present Complete Form, ID & PPO Medical Insurance Card to Front Desk to Allow for Copies

**Fax: 888-999-1887** **Phone: 888-240-7735**