ENDRES GATEWAY DENTISTRY

"Oral Health is the Gateway to Healthy Living"

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)?	☐	☐
Are you currently being treated for OSA?	☐	☐
Are you aware of a family history of OSA?	☐	☐
Are you aware of clenching or grinding your teeth at night?	☐	☐

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 in a lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____