# Sleep Disorder Assessment

Your Dentist requests that you complete this Sleep Disorder Assessment Form. This form evaluates the need for you to have a user friendly home sleep test. The home sleep test will determine if you have a sleep disorder. Sleep disorders negatively affect your well-being, especially your cardiovascular health. Sleep disorders can be treated effectively.

**Patient Name: _____ Date: _____**

**Primary Care Provider Name: _____ Phone Number: _____**

1. Have you ever been given a CPAP device?.....Yes___No___
2. If you have been given any form of CPAP, do you use it nightly……...Yes___No___
3. Are you comfortable with your CPAP and satisfied with its use……...Yes___No___

**If the answer is "No" to all three questions, <u>YOU ARE DONE!</u>**

**If your answer is "Yes" to any of the above questions, please continue to Part 1.**

## <u>Part 1 Epworth Sleepiness Scale</u>

How likely are you to doze off while doing the following activities? Please use the following scale:

**0 = never 1 = slight 2 = moderate 3 = high Circle one of the following numbers.**

1. Being a passenger in a motor vehicle for an hour or more?..... 0 1 2 3
2. Sitting and talking to someone?…… 0 1 2 3
3. Sitting and reading?……... 0 1 2 3
4. Watching TV?……... 0 1 2 3
5. Sitting inactive in a public place?……. 0 1 2 3
6. Lying down to rest in the afternoon?……..... 0 1 2 3
7. Sitting quietly after lunch without alcohol?……..... 0 1 2 3
8. In a car, while stopped for a few minutes in traffic?……..... 0 1 2 3

## <u>Part 2</u>

1. Have you ever been told you snore……..... Yes___No___
2. Does your family have a history of premature death……..... Yes___No___
3. Do you have diabetes……... Yes___No___

4. Have you ever been told you have coronary artery heart disease.....Yes___No___
5. Do you have high blood pressure……...Yes___No___
6. Have you ever experienced irregular heart rhythms…….....Yes___No___

**Part 3**

1. Have you ever been diagnosed with sleep apnea…….....….Yes___No___
2. Do you awaken from sleep with chest pain or shortness of breath.… .....Yes___No___
3. Has anyone said you seem to stop breathing while sleeping…….....Yes___No___
4. Is your neck size larger than 15" (female) 16.5 (male)……...Yes___No___
5. Have you ever had a stroke…….Yes___No___
6. Have you ever been told you have congestive heart failure…….....….....Yes___No___
7. Do you have or did you ever have atrial fibrillation…….....…… Yes___No___

I give Dr. Bailey and Dr. Popp permission to contact primary care provider with sleep disorder findings.

Patients Signature: _____

Dentist Signature: _____