PEAK Dental Specialists

Patient Sleep Evaluation Form

Patient Name:_____

DOB:_____ Gender: M_____ F_____ Height:_____ Weight:_____

Please check any of the following you may have:		
☐ DIABETES	☐ Bruxism	☐ ERECTILE DYSFUNCTION
☐ STROKE	☐ OBESE	☐ FREQUENT URINATION AT NIGHT
☐ DEPRESSION	☐ HYPERTENSION	☐ MORNING HEADACHES
☐ GERD	☐ SNORING	☐ WACKING, CHOKING, GASPING FOR AIR

Please check YES or NO to the following questions:		
1. Do you snore or have been told that you snore?	☐ YES	☐ NO
2. Do you often feel tired, fatigued, or sleepy during daytime?	☐ YES	☐ NO
3. Has anyone observed you stop breathing or gasp for aire during your sleep?	☐ YES	☐ NO
4. Do you have or are you being treated for high blood pressure?	☐ YES	☐ NO

If you answered Yes to 2 or more of the above , please continue:

Epworth Sleepiness Scale Do you get sleepy….....	Never Dose Off	Slight chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
1. .....or doze off, while sitting and reading?	☐ 0	☐ 1	☐ 2	☐ 3
2. .....or doze off while watching TV?	☐ 0	☐ 1	☐ 2	☐ 3
3. .....while sitting or being inactive in a public place?	☐ 0	☐ 1	☐ 2	☐ 3
4. .....as a passsenger in a car for an hour without a break?	☐ 0	☐ 1	☐ 2	☐ 3
5. .....lying down to rest in the afternoon?	☐ 0	☐ 1	☐ 2	☐ 3
6. .....sitting and talking to someone?	☐ 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 at a traffic light?	☐ 0	☐ 1	☐ 2	☐ 3
			Total Score	

Have you ever been diagnosed with Sleep Apnea?	☐ YES	☐ NO
Are you currently using CPAP (or any other apnea/snoring device)	☐ YES	☐ NO
Are you currently taking any sleeping aids (prescribed or OTC)?	☐ YES	☐ NO
Are you aware of clenching or grinding your teeth?	☐ YES	☐ NO

Signature X:_____ **Date:**_____