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Patient Screening Form

Date:_______________

Name: ___________________________________ D.O.B. __________________ Sex: __________

Height: _________________________ Weight:_______________Neck Collar Size:_____________

Can Breathe through Nose: _________________ Do you wear Dentures?____________________

Health Quiz---

- Do you Snore? Yes / No
- Do you gasp/choke during sleep, witnessed, observed? Yes / No
- Do you feel sleepy, tired, fatigued, during the day? Yes / No
- Do you have high blood pressure or treated it? Yes / No
- Do you have or being treated for Diabetes? Yes / No

Epworth Sleepiness Scale---

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your unusual way of life in recent times. Even if you haven't done some of these things recently, try to think about how they would have affected you. Use the following scale to choose the most appropriate number for each situation: (0-3 Chance of Dozing) **0**= Never **1**= Moderate Chance **2**= Slight Chance **3**= Moderate Chance

Chance of Dozing (Score 0-3)	**Situation**
__________	Sitting and Reading
__________	Watching TV
__________	Sitting, Inactive in a public place (i.e. theater or in a meeting)
__________	As a passenger in a car for an hour without a break
__________	Lying down to rest in the afternoon when circumstances permit
__________	Sitting and talking to someone
__________	Sitting quietly after a lunch without alcohol
__________	In a car while stopped for a few minutes in traffic

Total: ________________ **Total this (This is your Epworth Score)**

Summary:

___ You answer 2 or more on Health quiz

___ Epworth Sleepiness scale is 9 or greater

___ Combination of 9 or more on health quiz and Epworth Sleepiness scale

___ Neck size is > 15 inches

Sleep History:

Have you ever been diagnosed with a sleep disorder? Y / N

Do you currently use a CPAP machine? Y / N

Do you use a CPAP less than 4 days a week? Y / N

Would you prefer an oral appliance? Y / N

Do you wear a denture? Y / N