SOUTH SHORE DENTAL GROUP
Sleep Disorder Assessment

Phone: 781-843-7800
Fax: 781-356-8182

Date ____________________ Gender Male Female

Name ____________________ Date of Birth ____________________

Address ____________________

City ____________________ State __________ Zip Code ____________________

Have you been diagnosed with sleep apnea in the past? **Yes** No

Do you use or have you used CPAP? Yes, still use Yes, but no longer use No, never recommended

Are you intolerant of the CPAP or are you seeking to get rid of your CPAP and use an oral appliance? **Yes** **No**

Symptoms and Medical History

Question		
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	☐ Yes	☐ No
Do you often feel tired, fatigued or sleepy during the daytime?	☐ Yes	☐ No
Have you experienced episodes of falling asleep when you should be alert or sleepiness while driving?	☐ Yes	☐ No
Has anyone observed you stop breathing during your sleep?	☐ Yes	☐ No
Have you ever been told or noticed that you wake from sleep choking or gasping for air?	☐ Yes	☐ No
Do you wake frequently from sleep or wake up not feeling rested?	☐ Yes	☐ No

Do you have any of these medical conditions? Check all that apply:

- ☐ Hypertension
- ☐ Stroke
- ☐ Type 2 diabetes mellitus
- ☐ Atrial fibrillation
- ☐ Coronary artery disease/ myocardial infarction

Neck Size ____________________ ☐ Increased risk with > 17” in men, >16” in women

Height __________ Weight __________ BMI __________ ☐ Increased risk if BMI >30 (we will detemine this for you)

Patient Self Assessment: Part 1

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
1. Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
2. Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
3. Sitting inactive in a public place (e.g., a theater or a meeting)	☐ 0	☐ 1	☐ 2	☐ 3
4. As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
5. Lying down to rest in the afternoon when circumstances permit	☐ 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 in traffic	☐ 0	☐ 1	☐ 2	☐ 3

Total ____/24

Patient Self Assessment: Part 2

1. During the last two weeks, please rate the severity of your sleep problem(s).

	None	Mild	Moderate	Severe	Very severe
a. Difficulty falling asleep	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
b. Difficulty staying asleep	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
c. Problem waking up too early	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4

	Very satisfied	Satisfied	Moderately satisfied	Dissatisfied	Very dissatisfied
2. How satisfied or dissatisfied are you with your current sleep pattern?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4

	Not at all noticeable	A little	Somewhat	Much	Very much noticeable
3. How noticeable to others do you think your sleep problem is in terms of impairing the quality of your life?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4

	Not at all worried	A little	Somewhat	Much	Very much worried
4. How worried or distressed are you about your current sleep problem?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4

	Not at all interfering	A little	Somewhat	Much	Very much interfering
5. To what extent do you consider your sleep problem to currently interfere with your daily functioning (e.g., daytime fatigue, mood, ability to function at work, daily chores, concentration, memory, etc.)	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4

Total ____/28

Please bring this completed form to our office for you initial evaluation and assessment.
We will provide you with direction and referral to the appropriate health care provider to evaluate the severity of your sleep problem and provide appropriate care.