Dr. Judy Tiffany
Monarch View Dental
Sleep Health Questionnaire

Name	*Gender*	*DOB*
Address, City, State, Zip	*Weight*	*Height*
Cell Phone	*Alt. Phone*	*Email*
PPO Medical Insurance Company **(PPO Only)**	*ID#*	*Group#*

Section 1- Patient Sleepiness Scale

Step 1: Answer "Yes" or "No" for the following questions (circle Y or N). If you answer "yes" also circle the corresponding points in the column to the right.

Step 2: Total the points that you circled in the right column and record score in the space below.

1. Have you ever been told you stop breathing while asleep?	*Yes*	*No*	*8*
2. Have you ever fallen asleep or nodded off while driving?	*Yes*	*No*	*6*
3. Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	*Yes*	*No*	*6*
4. Do you feel excessively sleepy during the day?	*Yes*	*No*	*4*
5. Do you snore or have you ever been told that you snore?	*Yes*	*No*	*4*
6. Have you had gained weight gain and found it difficult to lose?	*Yes*	*No*	*2*
7. Have you taken medication for, or been diagnosed with high blood pressure	*Yes*	*No*	*2*
8. Do you kick or jerk your legs while sleeping?	*Yes*	*No*	*3*
9. Do you feel burning, tingling or crawling sensations in your legs when you wake up?	*Yes*	*No*	*3*
10. Do you have trouble falling asleep?	*Yes*	*No*	*4*
11. Do you have trouble staying asleep once you fall asleep?	*Yes*	*No*	*4*

Score

Risk Level	*Low*	*Moderate*	*High*	*Severe*
Score	*0-7*	*8-11*	*12-15*	*16+*

Patient Name: _____

Section 2- Signs & Symptoms (Check all that apply):

- ☐ Hypertension
- ☐ Snoring
- ☐ Diabetes
- ☐ Depression
- ☐ Grind Teeth
- ☐ Acid Reflux
- ☐ Stroke/Heart Disease
- ☐ Unrefreshed Sleep
- ☐ Family history of Snoring or Sleep Apnea

Section 3-Sleep History (Check all that apply):

Have you ever been diagnosed with a sleep disorder?	Yes	No
Are you currently using a CPAP machine?	Yes	No
Do you use your CPAP less than 5 times a week?	Yes	No
Would you prefer an oral appliance?	Yes	No

For Provider Use