



David T. Rothan, DDS, General Dentist • Michael J. Rothan, DDS, General Dentist

Initial Sleep Screening

Patient Name (PRINT) _____

Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations: (0=never, 1=slight, 2=moderate, 3=high chance of dozing) – CIRCLE ONE RESPONSE FOR EACH QUESTION

Table with 5 columns: Situation, 0, 1, 2, 3. Rows include: Sitting and reading, Watching television, Sitting in a public place, As a passenger in a car for one hour, Driving a car stopped for a few minutes in traffic, Sitting & talking to someone, Sitting down quietly after lunch without alcohol, Lying down to rest in the afternoon.

Total Score: _____

Section 2: Patient Evaluation

Fill in the blanks, circle one yes or no response for each question

No (0) Yes (1)

Table with 2 columns: Question, 0, 1. Rows include: BMI, Body Mass Index (See Chart): _____ is it greater than or equal to 30?, Neck Circumference _____ is it >17" (Men) or >15" (Women)?, Have you gained at least 15lbs in the past 6 months?

Total Score: _____

Section 3: Subjective Sleep Evaluation

Please circle one yes or no response for each question

No (0) Yes (1)

Table with 2 columns: Question, 0, 1. Rows include: Do you snore?, You, or your spouse, would consider your snoring louder than a person talking, Your snoring occurs almost every night, Your snoring is bothersome to your bed partner, Do you feel that in some way your sleep is not refreshing or restful?, Do you wake up at night or in the mornings with headaches?, Do you experience fatigue during the day and have difficulty staying awake?, Do you have trouble remembering things or paying attention during the day?, Do you have high blood pressure?

Total Score: _____

Section 4: Prior Diagnosis

No (0) Yes (1)

Table with 2 columns: Question, 0, 1. Row: Have you previously been diagnosed with sleep apnea?

If Yes:

When were you diagnosed? (Approx mo/yr) _____
Were you put on CPAP Therapy for treatment? _____
Are you still using your CPAP every night? _____

Total Score: _____

Notes: (Please insert any notes for the doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate use back of page.)

Patient Signature: _____ Date: ____ / ____ / ____

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Advanced screening criteria, if yes to any below pt should be scheduled for advanced OSA screening.

_____ ESS Score ≥ 8? _____ Pt. Eval ≥ 2? _____ Subjective Sleep Eval ≥ 3? _____ Prior OSA Diagnosis ≥ 1?