purpleplum
DENTISTRY
Anita Kianimanesh, DMD

Patient's Name:_____Date of Birth: _____
Phone (home): _____(work)_____ (cell) _____
Patient's Doctor: _____
Doctor's address: _____ Phone: _____
Referring Specialist's Name:_____ Phone: _____

Medical conditions often co-morbid with obstructive sleep apnea. Ask patient if they suffer(ed) from:

Hypertension/drug resistant hypertension	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
GERD/acid reflux	☐ Yes	☐ No
Heart disease/coronary artery disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No

Snoring and sleep disordered breathing conditions. Ask the patient:

1.	Do you snore or have you been told you snore?	☐ Yes	☐ No
2.	Do you snore only when you are lying on your back?	☐ Yes	☐ No
3.	Do you snore every night?	☐ Yes	☐ No
4.	Have you been told you stop breathing or gasp during sleep?	☐ Yes	☐ No
5.	Has your partner had to move to another room during the night?	☐ Yes	☐ No
6.	Are you currently or have you been treated for high blood pressure?	☐ Yes	☐ No
7.	Do you doze off unintentionally during the day?	☐ Yes	☐ No
8.	Do you fall asleep when driving?	☐ Yes	☐ No
9.	Do you often awaken feeling tired?	☐ Yes	☐ No
10.	Do you often awaken with a headache?	☐ Yes	☐ No
11.	Do you have problems concentrating for long periods of time?	☐ Yes	☐ No
12.	Are you having accidents on the job or at home?	☐ Yes	☐ No
13.	Do you feel pain in your jaw joints in the area of the ear?	☐ Yes	☐ No
14.	Do you grind or clench your teeth in your sleep?	☐ Yes	☐ No
15.	Do you suspect you have sleep apnea?	☐ Yes	☐ No
16.	Have you ever been treated for snoring, a sleep disorder, or sleep apnea?	☐ Yes	☐ No
17.	Have you ever participated in a sleep study?	☐ Yes	☐ No

- When?_____ Where?_____
  _____
- How is C-PAP working for you? _____

Family History

Have any family members had heart disease/high blood pressure/diabetes?	☐ Yes	☐ No
Do any family members snore, have sleep apnea, or a sleep disorder?	☐ Yes	☐ No

If yes, who? _____

Personal History and Anatomy

Age: _____ Weight:_____ Height: _____
Neck circumference: _____ Risk factor: Male > 43cm; Female > 41cm
Alcohol consumption (number of drinks per week)_____
Are there potential obstructions to the airway?
☐ enlarged tonsils ☐ enlarged tongue ☐ enlarged uvula ☐ enlarged adenoids ☐ recessed chin

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

0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g.: a theater or a meeting)	
Riding 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	
Riding in a car, while stopped for a few minutes in traffic	

Total your points and evaluate your score against the table below:

1-6 = Congratulations, you are getting enough sleep!
7-8 = Your score is average
9 and up = Seek the advice of a sleep specialist without delay

Purple Plum Dentistry
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Sleep Screening Questionnaire

Please answer the questions below to help us assess the possibility of a sleep disorder which may be related to your dental and overall health. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke. If you are here with your child (under 16), please fill out the lower portion marked "For children only" for your child.

Name:_____ **Height:**_____ **Weight:**_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	**Chance of Dozing**
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theater or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____
Total Score	_____

Have you ever been diagnosed with:	**Yes**	**No**
1. Impaired Cognition (i.e. difficulty concentrating or thinking)	❑	❑
2. Mood Disorders/Depression	❑	❑
3. Insomnia	❑	❑
4. Hypertension (high blood pressure)	❑	❑
5. Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	❑	❑
6. History of Stroke	❑	❑
7. Sleep Apnea	❑	❑
If yes: Did you try to use CPAP	❑	❑
8. TMJ problems significant enough to require treatment	❑	❑
9. Gastric Reflux (GERD) or Heartburn	❑	❑

Are you aware of (or have you been told):	**Yes**	**No**
1. Snoring on a regular basis	❑	❑
2. Feeling tired or fatigued on a regular basis	❑	❑
3. Clenching or grinding your teeth (bruxism)	❑	❑
4. Having frequent headaches	❑	❑
5. Your neck size being > 17 inches (male) or > 16 inches (female)	❑	❑
6. Anyone in your family having sleep apnea	❑	❑
7. Stopping breathing when sleeping/awakening with a gasp	❑	❑

For children only (filled out by parent or guardian)

Are you aware of your child:	**Yes**	**No**
1. Snoring/noisy breathing while sleeping	❑	❑
2. Grinding his or her teeth	❑	❑
3. Wetting the bed	❑	❑
4. Having difficulty in school/learning	❑	❑
5. Being treated for ADD or ADHD	❑	❑
6. Breathing primarily through their mouth	❑	❑
7. Having frequent nightmares/night terrors	❑	❑
8. Having frequent ear aches	❑	❑

Dental Exam Findings:

❑ **Evidence of Bruxism** ❑ **Scalloping of the tongue** ❑ **Crowded airway**
❑ **Tori or Bone Loss** ❑ **Anterior wear** ❑ **Retrognathia / Class II**
❑ **Mallampati 3 or 4** ❑ **Vaulted Palate** ❑ **Narrow Upper Arch**