If you answered yes to #30, please fill out this Sleep Health Questionnaire

Patient Name: (PRINT)	Sex:	Birthdate:

CURRENT THERAPIES

Have you attempted CPAP therapy?	**Y**	**or**	**N**
- If yes, are you able to use it at least 5 nights a week (6 or more hours per night)?	**Y**	**or**	**N**
Have you undergone any surgical attempts to correct your sleep apnea?	**Y**	**or**	**N**
Would you prefer an oral device (appliance) rather than a CPAP?	**Y**	**or**	**N**
Have you tried any of the following conservative methods of improving your sleep breathing?(Please check)	**Y**	**or**	**N**
☐ **Weight loss**			
☐ **Positional therapy: Avoiding sleeping on your back during sleep (the supine position)**			
☐ **Abstaining from the use of alcohol and/or sedatives before bedtime**			

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.**

Have you ever been told you stop breathing while asleep?	**Y**	**or**	**N**	**8**
Have you ever fallen asleep or nodded off while driving?	**Y**	**or**	**N**	**6**
Have you ever woken up seddenly with shortness of breath, gasping or with you heart racing?	**Y**	**or**	**N**	**6**
Do you feel excessively sleepy during the day?	**Y**	**or**	**N**	**4**
Do you snore or have you ever been told that you snore?	**Y**	**or**	**N**	**4**
Have you had weight gain and found it difficult to lose?	**Y**	**or**	**N**	**2**
Have you taken mediation for or been diagnosed with high blood pressure?	**Y**	**or**	**N**	**2**
Do you kick or jerk your legs while sleeping?	**Y**	**or**	**N**	**3**
Do you feel a burning, tingling or crawling sensation in your legs when you wake up?	**Y**	**or**	**N**	**3**
Do you wake up with headaches during the night or in the morning?	**Y**	**or**	**N**	**3**
Do you have trouble falling asleep?	**Y**	**or**	**N**	**4**
Do you have trouble staying asleep once you fall asleep?	**Y**	**or**	**N**	**4**
		SCORE		

RISK LEVEL	Low	Moderate	High	Severe+
Score	0-7	8-11	12-15	16+

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