DENTAL ASSOCIATES OF DELAWARE — Sleep Evaluation

Complete the following: Height_____ Weight_____ Age_____ Female ☐ Male ☐

1. Do you snore?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

IF YOU SNORE:

2. Your snoring is?
   - ☐ Slightly louder than breathing
   - ☐ As loud as talking
   - ☐ Very loud
   - ☐ Can be heard in adjacent rooms

3. How often do you snore?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

4. Has your snoring ever bothered other people?
   - ☐ Yes
   - ☐ No

5. Has anyone noticed that you quit breathing during your sleep?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

6. How often do you feel tired or fatigued after your sleep?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

7. During your wake-time, do you feel tired, fatigued or not up to par?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
   - ☐ Yes
   - ☐ No

   If yes, how often does it occur?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

9. Do you have high blood pressure?
   - ☐ Yes
   - ☐ No

Scoring: Any answer within a highlighted box is a positive response.
Category 1 is positive with 2 or more positive response to questions 1-5 ☐
Category 2 is positive with 2 or more positive responses to questions 6-8 ☐
Category 3 is positive with 1 positive response to question 9 and/or a BMI>30 ☐ (BMI = Body Mass Index)

Final Result: 2 or more possible categories indicate a high likelihood of sleep disordered breathing.

Patient Signature_____ Date_____

***Office Use Only*:** Patient's Name_____ Account No._____