Windsor
PROGRESSIVE
DENTAL CARE

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Sleep Survey

Patient Name: _____

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

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting in a public place	0	1	2	3
As a passenger in a car for one hour	0	1	2	3
Driving a car stopped for a few minutes in traffic	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting down quietly after lunch without alcohol	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3

Total Score _____

Section 2: Subjective Sleep Evaluation

Please circle one (yes or no) response for each question	No(0)	Yes(1)
Do you snore?	0	1
You, or your spouse, would consider your snoring louder than a person talking	0	1
Your snoring occurs almost every night	0	1
Your snoring is bothersome to your bed partner	0	1
Do you feel that in some way your sleep is not refreshing or restful?	0	1
Do you wake up at night or in the mornings with headaches?	0	1
Do you experience fatigue during the day and have difficulty staying awake?	0	1
Do you have trouble remembering things or paying attention during the day?	0	1
Do you have high blood pressure?	0	1

Total Score _____

Section 3: 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? _____