YAP FAMILY DENTAL

General Patient Sleep Screening Form

Patient Name (PRINT)_____Date_____

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 & 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: Prior Diagnosis

	No(0)	Yes(1)
Have you been through a sleep study before?	0	1
Have you previously been diagnosed with sleep apnea?	0	1

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: _____

Patient Signature:_____ **Date:** ____/____/_____

Section 4: Patient Evaluation (STAFF ONLY-Lay patient back)

Tongue Position- Malampatti Scoring……(Stick out tongue)…….	1	2	3	4
Pharyngeal Grading- Sampsoon-Young Classification (say 'AH')…….	1	2	3	4
Tonsil Classification- Brodsky Classification…(say 'AH')…….	1	2	3	4

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 if necessary.)

OFFICE USE ONLY
Advanced screening criteria, if yes to any below pt should be scheduled for advanced OSA screening.
_____ ESS Score ≥ 8? _____ Subjective Sleep Eval ≥ 3? _____ Prior OSA Diagnosis ≥ 1? _____ Pt. Eval ≥6?