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OSHINS OF SMILES
Advanced Dentistry for Total Body Wellness

Sleep Apnea Patient Questionnaire

Patient Name *

First Name | Middle Name | Last Name

Date *

Month | Day | Year

STOP-BANG Patient Questionaire

Please answer the questions below to help us see if you might have sleep apnea. This is when your breathing pauses sometimes while you are sleeping.

	Yes	No
SNORING - Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	○	○
TIREDNESS/FATIGUE - Do you often feel tired, fatigued, or sleepy during the daytime, even after a "good" night's sleep?	○	○
OBSERVED APNEA - Has anyone ever observed you to stop breathing during your sleep?	○	○
PRESSURE - Do you have or are you being treated for high blood pressure?	○	○
BODY MASS INDEX - More then 35? (BMI Formula: weight (lb) / Height (in)2 x 703)	○	○
AGE - Are you older than 50 years?	○	○
NECK SIZE - Does your neck measure more than 15 ¾ inches (40 cm) around?	○	○
GENDER - Are you male?	○	○

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of medicine as a subjective measure of a patient's sleepiness. How likely are you to dose off or fall asleep during the following situations, in contrast to just feeling tired?

For each of the situations listed below, select a score of 0 to 3

0 = *Would never doze*; 1 = *Slight chance of dozing*;

2 = *Moderate chance of dozing*; 3 = *High chance of dozing*

*

	0	1	2	3
Sitting and Reading	○	○	○	○
Watching Television	○	○	○	○
Sitting inactively in a public place (for example a theater or meeting)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch (when you've had no alcohol)	○	○	○	○
In a car, when stopped in traffic	○	○	○	○

Total Epworth Score