SLEEP SURVEY

JAX BEACHES
FAMILY DENTISTRY

NAME _____ DATE OF BIRTH _____ AGE _____

HEIGHT (feet/inches) _____ WEIGHT _____

I AFFIRM ANSWERS ARE TRUTHFUL. SIGNATURE _____ DATE _____

Use scale below to choose the most appropriate number for each situation, and sum the numbers at the bottom:

0 = would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
Sitting as passenger in vehicle for an hour	0	1	2	3
In a vehicle and stopped for a few minutes	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (no alcohol)	0	1	2	3
Total Column				

TOTAL SCORE /24

PLEASE CHOOSE THE CORRECT RESPONSE TO EACH QUESTION IN REGARD TO SNORING.

DO YOU SNORE OR BEEN TOLD YOU SNORE?

- ◯ Yes
- ◯ No
- ◯ Don't know

HAS YOUR SNORING BOTHERED OTHERS?

- ◯ Yes
- ◯ No
- ◯ Don't know

IF YOU SNORE, YOUR SNORING IS

- ◯ Slightly louder than breathing
- ◯ As loud as talking
- ◯ Can be heard in adjacent rooms

HAS ANYONE NOTICED YOU QUIT BREATHING DURING SLEEP?

- ◯ Daily
- ◯ Sometimes
- ◯ Never

Learn more

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PLEASE CHOOSE THE CORRECT RESPONSE TO EACH QUESTION.

HOW OFTEN DO YOU FEEL FATIGUED OR TIRED AFTER YOU SLEEP?

- ◯ Nearly every day
- ◯ 3-4 times a week
- ◯ 1-2 times a week
- ◯ 1-2 times a month
- ◯ Never, or nearly never.

WHILE WALKING, 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.

HAVE YOU FALLEN ASLEEP OR NODDED OFF WHILE DRIVING A VEHICLE?

◯ Yes ◯ No

IF YES, HOW OFTEN DOES THIS OCCUR?

- ◯ Nearly every day
- ◯ 3-4 times a week
- ◯ 1-2 times a week
- ◯ 1-2 times a month
- ◯ Never, or nearly never.

DO YOU HAVE HIGH BLOOD PRESSURE?

◯ Yes ◯ No

DO HAVE TROUBLE FALLING ASLEEP?

◯ Yes ◯ No

DO YOU HAVE TROUBLE STAYING ASLEEP?

◯ Yes ◯ No

PLEASE MARK ALL THAT APPLY.

SLEEP SYMPTOMS

- ◯ Burning, tingling legs upon wakening
- ◯ Frequent bathroom visits nightly
- ◯ Gasping, choking, snorting during sleep
- ◯ Restless legs
- ◯ Limbs jerking/twitching at night
- ◯ Morning headache
- ◯ Insomnia
- ◯ Restless sleep
- ◯ Memory loss
- ◯ Teeth grinding/clenching
- ◯ Waking up paralized
- ◯ Audible or visual hallucinations around sleep
- ◯ Family history of sleep apnea
- ◯ Weight gain/difficult to lose weight

MEDICATIONS (NAME ONLY)

_____

_____

_____

PREVIOUS SLEEP DIAGNOSES AND TREATMENT

- ◯ Sleep study in lab
- ◯ CPAP/BiLevel Therapy
- ◯ Dental splint for snoring or OSA
- ◯ Positional therapy
- ◯ Apnea surgery
- ◯ Weight loss

Would you prefer an oral device?

◯ Yes ◯ No

HEALTH ISSUES. MARK ALL THAT APPLY.

- ◯ Heart disease
- ◯ Stroke
- ◯ Lung disease
- ◯ Acid reflux
- ◯ Chronic pain
- ◯ Fibromyalgia
- ◯ Diabetes
- ◯ High blood pressure
- ◯ Oxygen use
- ◯ Pacemaker
- ◯ Depression
- ◯ Erectile dysfunction

Alcohol consumption

◯ Daily ◯ Weekly ◯ Special occassions