**dental partners** of Vero Beach

*Comprehensive Dentistry*
*Airway Orthodontics*
*& Sleep Solutions*
*For Patients of All Ages*

# Sleep Risk Assessment Questionnaire, Adult

Patient Name: ______________________ Height: ______________________
Primary Phone: ______________________ Weight: ______________________
Date of Birth: ______________________ Gender: ______________________
Age: ______________________ General Practitioner: ______________________
Do you feel you may have sleep apnea? ❑ Yes ❑ No
Do you smoke? ❑ Yes ❑ No

**Instructions:** Use the scale below to choose the most appropriate response for each situation. Please Check Off

| Situation | Chance of Dozing | | | |
|---|---|---|---|---|
| | **Never** | **Slight** | **Moderate** | **High** |
| Sitting and reading | ❑ | ❑ | ❑ | ❑ |
| Watching TV | ❑ | ❑ | ❑ | ❑ |
| Sitting inactive in a public place | ❑ | ❑ | ❑ | ❑ |
| As a passenger in a car for an hour | ❑ | ❑ | ❑ | ❑ |
| Laying down in afternoon | ❑ | ❑ | ❑ | ❑ |
| Sitting and talking to someone | ❑ | ❑ | ❑ | ❑ |
| Sitting quietly after lunch (no alcohol) | ❑ | ❑ | ❑ | ❑ |
| In a car and stopped for a few minutes | ❑ | ❑ | ❑ | ❑ |

Other: ______________________________________________

______________________________________________

______________________________________________

Do you snore? ❑ Yes ❑ No
If Yes, Complete the following section, If No, proceed to next section
If you snore, your snoring is
❑ As loud as talking ❑ Can be heard in adjacent rooms
❑ Louder than talking ❑ Slightly louder than breathing

Has your snoring bothered other people ❑ Yes ❑ No ❑ Don't Know

| | Nearly Everyday | 1-2 Times A Week | 3-4 Times A Week | 1-2 Times A Month | Never or Nearly Never |
|---|---|---|---|---|---|
| How often do you snore? | ❑ | ❑ | ❑ | ❑ | ❑ |
| Has anyone noticed that you stopped breathing while sleeping? | ❑ | ❑ | ❑ | ❑ | ❑ |
| Have you ever fallen asleep or nodded off driving a vehicle? | ❑ | ❑ | ❑ | ❑ | ❑ |
| Has anyone noticed that you quit breathing in your sleep? | ❑ | ❑ | ❑ | ❑ | ❑ |
| How often do you feel fatigued or tired after your sleep? | ❑ | ❑ | ❑ | ❑ | ❑ |
| During your wake time, do you feel tired, fatigued, or not up to par? | ❑ | ❑ | ❑ | ❑ | ❑ |

Please complete 2nd Page ➔

# Sleep Risk Assessment Questionnaire, Adult **pg.2**

*Please Check All That Apply*

## Sleep Symptoms

- Frequent Bathroom Visits Nightly ❑
- Gasping, Choking or Snorting During Sleep ❑
- Restless Legs ❑
- Limbs Jerking/Twitching At Night ❑
- Moring Headaches ❑
- Insomnia ❑
- Restless Sleep ❑
- Memory Loss ❑
- Waking Up Paralyzed ❑
- Teeth Grinding/Clenching ❑
- Audible or Visual Hallucinations Around Sleep ❑
- Family History of Sleep Apnea ❑

*Please Check All That Apply*

## Health Issues

- Heart Disease ❑
- Stroke ❑
- COPD ❑
- Other Lung Disease ❑
- Gastric Acid Reflux ❑
- Chronic Pain ❑
- Fibromyalgia ❑
- Diabetes ❑
- High Blood Pressure ❑
- Oxygen Use ❑
- Pacemaker ❑
- Depression ❑
- Erectile Dysfunction ❑

Alcohol Consumption Please specify: ❑ Daily ❑ Weekly ❑ 3-5 times a week ❑ Weekends ❑ Special Occasions

Previous Oral/nasal surgery (if yes, specify) ______________________________

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