ROCKY CREEK DENTAL CARE SLEEP QUESTIONNAIRE

Name: ______________________________________ Date: ________________

DOB: ______________ Male _____ Female _____ Ht: _______ Wt: ________

General Physician: ________________________

Please check any of the following you may have:

___ High Blood Pressure ___Heart Disease ___Diabetes ___Stroke ___Weight Gain

___ Acid Reflux ___Depression ___Anxiety ___Insomnia ___Sleep Apnea

Are you currently using a CPAP machine? ___*Y* ___*N* *If yes, every night?* ___*Y* ___*N*

Have you ever had a Sleep Study? ___*Y* ___*N*

Do you have frequent headaches? ____Y ____N

Do you wake up with soreness or tension in your jaw muscles or teeth? ____Y ____N

Y	N	8	Have you ever been told you stop breathing while you sleep?
Y	N	6	Have you ever fallen asleep or nodded off while driving?
Y	N	6	Have you ever woken up suddenly with shortness of breath, gasping, or racing heart?
Y	N	4	Do you fight sleepiness during your normal daytime routine?
Y	N	4	Do you snore, or have you been told that you snore?
Y	N	2	Have you had weight gain and found it difficult to lose?
Y	N	2	Have you taken medication for, or been diagnosed with high blood pressure?
Y	N	3	Do you kick or jerk your legs while sleeping?
Y	N	3	Do you feel burning, tingling or crawling sensations in your legs when you wake up?
Y	N	3	Do you wake up with headaches during the night or morning?
Y	N	4	Do you have trouble falling asleep?
Y	N	4	Do you have trouble staying asleep once you fall asleep?

FOR CLINICAL USE ONLY

Low	***Moderate***	***High***	***Severe***
0 -7	*8 - 11*	*12 - 15*	*16+*