iSLEEP PROGRAM

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Dental Sleep Health Questionnaire

Name: _____ **Date:** _____

1. Do you snore or have been told by someone that you snore?	☐ Yes (2 pts	☐ No
2. Has anyone ever noticed that you quit breathing during your sleep?	☐ Yes (3 pts)	☐ No
3. Do you ever awaken with a sensation of gasping or choking?	☐ Yes (3 pts)	☐ No
4. Do you often wake up with a dry mouth?	☐ Yes (2 pt)	☐ No
5. Do you find your sleep to be non-refreshing?	☐ Yes (2 pts)	☐ No
6. During your waking time, do you often feel tired, fatigued or not up to par?	☐ Yes (1 pt)	☐ No
7. Do you fall asleep in any situation(s) where you did not intend to?	☐ Yes (1 pt)	☐ No
8. Do you have (or are being treated for) high blood pressure and/or diabetes?	☐ Yes (1 pt)	☐ No

Total Points: _____

Please add up the number of questions that were answered "yes". If the number of questions answered "Yes" is greater than 2 the patient is a candidate for a diagnostic sleep study.

0 - 2 = Lower risk of having Obstructive Sleep Apnea
3 - 6 = Moderate risk of having Obstructive Sleep Apnea
7 - 15 = High risk of having Obstructive Sleep Apnea

This questionnaire utilizes portions of the Berlin questionnaire, Epworth Sleepiness Scale (ESS) and STOP-BANG questionnaire , which are widely recognized by the AASM as diagnostic tools for obstructive sleep apnea syndrome (OSAS)