QUESTIONNAIRE FOR POTENTIAL SLEEP APPLIANCE PATIENTS

Who referred you to this office for consultation? _____

Have you been diagnosed as having a sleep disorder? _____ If so, what? _____

Have you had an overnight study in a sleep disorders center? _____

If Yes, what was the result of that study? _____

Do you have excessive sleepiness in the daytime with your normal activity? ____ While driving? ____

Do you frequently have a headache in the morning? _____

Do you have high blood pressure? _____ If Yes, is it being treated? _____

Do you snore? _____ Have you been told you stop breathing during your sleep? _____

How tall are you? _____ ft. _____ in. How much do you weigh? _____ pounds.

EPWORTH SLEEPINESS SCALE QUESTIONNAIRE

The following sleepiness scale can be helpful in determining how much sleeping disorder you have. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Use the following scale to choose the *most appropriate number for* each situation.

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

SITUATION	**CHANCE OF DOZING**
Sifting and reading	_____
Watching Television	_____
Sitting, inactive in a public place (theater or movie)	_____
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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

EPWORTH SCALE RESULTS: 1-12: Snoreguard therapy indicated
13-24: Consider medical referral prior to appliance therapy.