TMJ & Sleep Therapy Centre
of Northern Indiana

Sleep Evaluation Questionnaire

Patient: _____ DOB: _____/_____/_____
Today's date: __/__/__ BMI: _____

Have you been told you have sleep apnea?	Yes ☐	No ☐
Have you been told to wear a CPAP or any other device for breathing at night?	Yes ☐	No ☐
If yes, do you wear it every night for the entire night?	Yes ☐	No ☐
Do you take medication, supplements, or over-the-counter substances as sleep aids or headache relief?	Yes ☐	No ☐
Do you feel rested in the morning?	Yes ☐	No ☐

Please check if you have any of the following:

Heart Disease ☐	Insomnia ☐	Diabetes ☐
Headaches ☐	Depression ☐	Urination at night (nocturia) ☐
Acid Reflux ☐	Stroke ☐	Tooth grinding ☐

STOP BANG SCORE:

Do you SNORE?	Yes ☐	No ☐
Do you feel TIRED?	Yes ☐	No ☐
Has anyone OBSERVED you stop breathing during sleep?	Yes ☐	No ☐
Do you have or are you being treated for high blood PRESSURE?	Yes ☐	No ☐
Is your BMI > 30?	Yes ☐	No ☐
AGE: Are you > 50 years old?	Yes ☐	No ☐
Is your NECK circumference > 16"?	Yes ☐	No ☐
GENDER: Are you male?	Yes ☐	No ☐

Total Yes Responses: ____

3-4 = Moderate Risk for OSA, 5-8 = High Risk for OSA

EPWORTH SLEEPINESS SCALE:

Please indicate your chance of dozing off in the following situations using the following:

0- Would never doze
1- Slight chance of dozing
2- Moderate chance of dozing
3- High chance of dozing

Sitting and Reading	___	Laying down to rest in afternoon (when able)	___
Watching TV	___	Sitting and talking with someone	___
Sitting, inactive in public	___	Sitting quietly after lunch (w/o alcohol)	___
As a passenger in a car for an hour	___	In a car, stopped for a few minutes in traffic	___

Total: ___

0-6 Normal, 7-14 Mild Sleepiness, 15-17 Moderate Sleepiness, 18+ Severe Sleepiness

FOR OFFICE USE ONLY:

Patient meets the criteria for a comprehensive sleep evaluation and/or diagnostic sleep study. YES ☐ NO ☐