msd

Official Use Only: Epworth Score _____ STOP: High / Low BANG: High / Low

main street dental
Jodi Rump D.D.S.

Name _____ Date _____ Date of Birth _____

Height _____ Weight _____ BMI _____ Collar Size / Neck Circumference _____

Please answer Yes or No to the following.

Yes	No	
☐	☐	Have you ever been diagnosed with Obstructive Sleep Apnea (OSA)?
☐	☐	Are you currently being treated for OSA?
☐	☐	Are you aware of a family history of OSA?
☐	☐	Are you aware of clenching or grinding your teeth at night?

Using The Epworth Sleepiness Scale of 0 – 3…

No chance of dozing = **0** Slight chance of dozing = **1** Moderate chance of dozing = **2** High chance of dozing = **3**

How likely are you to doze off or fall asleep, in contrast to just feeling tired?

_____ Sitting and Reading

_____ Watching TV

_____ Sitting inactive in a public place, ie... theater or a meeting

_____ As a passenger in a car for an hour without a break

_____ Lying down to rest in the afternoon when circumstances permit

_____ Sitting and talking to someone

_____ Sitting quietly in a lunch without alcohol

_____ In a car while stopped for a few minutes in traffic

Please answer Yes or No to the following.

Yes	No	
☐	☐	**Snore** - Do you snore loudly? (Louder than talking or loud enough to be heard behind closed door?
☐	☐	**Tired** - Do you often feel tired, fatigued or sleepy during daytime?
☐	☐	**Obstruction** - Has anyone observed you stop breathing during your sleep?
☐	☐	**Pressure** - Do you have or are you being treated for high blood pressure?
☐	☐	**BMI** - Is your body mass index greater than 28?
☐	☐	**Age** - Are you 50 years old or older?
☐	☐	**Neck** - Are you a male with a neck circumference greater than 17 inches, or female greater than 16 inches?
☐	☐	**Gender** - Are you male?

If under physicians care please explain?_____ Physician's Name: _____

_____ Physician's Phone: _____

Notes: