Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fill out this form as accurately and honestly as possible. We want to address specific issues of breathing, rest posture and oral function that can affect your health and wellness. Use this scale to determine your level of sleepiness. Choose the most appropriate number for each situation:

|  |
| --- |
| 0 = no chance of dozing |
| 1 = slight chance of dozing or sleeping |
| 2 = moderate chance of dozing or sleeping |
| 3 = high chance of dozing or sleeping  |

|  |  |  |  |
| --- | --- | --- | --- |
|   |  |       | Chance of Dozing or Sleeping |
| Situation |
|  |
| Sitting and reading | \_\_\_\_ |
| Watching TV | \_\_\_\_ |
| Sitting inactive in a public place | \_\_\_\_ |
| As a passenger in a motor vehicle for an hour or more | \_\_\_\_ |
| Lying down to rest in the afternoon when circumstances permits | \_\_\_\_ |
| Sitting and talking to someone | \_\_\_\_ |
| Sitting quietly after lunch without alcohol | \_\_\_\_ |
| In a car, while stopped for a few minutes in traffic | \_\_\_\_ |
| Total score (add the scores up) (This is your Epworth score) | \_\_\_\_ |

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Please circle which one applies to you

1. Do you breath through your mouth?
2. Do you frequently get a dry throat or non-productive cough?
3. Do you have any nasal allergies?
4. Do you snore or have you been told you snore while sleeping?
5. Do you stop or pause your breathing while sleeping?
6. Do you wake up fatigued?
7. Do you have morning tension or migraine headaches?
8. Do you easily get tired or fall asleep during the day?
9. Do you clench or grind the teeth during the night?
10. Do you clench or grind the teeth during the day?
11. Do you have any facial pain?
12. Do you usually drink alcohol or take sleep aids before going to bed?
13. Do you suffer from hypertension?
14. Have you been diagnosed with Chronic Fatigue Syndrome, Irritable Bowel Syndrome, Fibromyalgia or Temporomandibular Syndrome? If so, please explain: