Willis Dental
Sleep Assessment

Name: _____ DOB: _____ Date: _____

Y / N Have you ever been diagnosed with a sleep disorder (sleep apnea)?
Y / N Is a Sleep Medicine physician treating your sleep disorder? Name of doctor_____.
Y / N Do you currently use a CPAP machine?
Y / N Do you use it every night?

If you answered no, please complete form.

This questionnaire was developed based upon the published finding of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

Please circle Y-yes or N-no, if yes the number is applied to the Score and Risk Factor total.

Y / N -8- Have ever been told you stop breathing while asleep?

Y / N -6- Have you ever fallen asleep or nodded off while driving?

Y / N -6- Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?

Y / N -4- Do you feel excessively sleepy during the day?

Y / N -4- Do you snore, or have you ever been told that you snore?

Y / N -2- Have you had a weight gain and found it difficult to lose?

Y / N -2- Have you taken medication for, or been diagnosed with high blood pressure?

Y / N -3- Do you kick or jerk your legs while sleeping?

Y / N -3- Do you feel burning, tingling or crawling sensations in your legs when you wake up?

Y / N -3- Do you wake up with headaches during the night or in the morning?

Y / N -4- Do you have trouble falling asleep?

Y / N -4- Do you have trouble staying asleep once you fall asleep?

Score and Risk Factor total_____

Low: 0-7, Moderate: 8-11, High: 12-15, Severe: 16+