Florida Craniofacial Institute

EPWORTH SLEEPINESS SCALE

Sitting and Reading	_____	0 = No chance of dozing
Watching TV	_____	1 = Slight Chance of dozing
Sitting inactive in public place (theater)	_____	2 = Moderate Chance of dozing
As a car passenger for an hour without a break	_____	3 = High Chance of dozing
Lying down in the afternoon to rest	_____	
Sitting and talking to someone	_____	
Sitting quietly after lunch without alcohol	_____	TOTAL = _____
In a car while stopped at a traffic light	_____	

THORNTON SNORING SCALE

My snoring affects my relationship with my partner	_____	0 = Never
My snoring causes my partner to be irritable or tired	_____	1 = 1 night/week
My snoring requires us to sleep in separate rooms	_____	2 = 2-3 nights/week
My snoring is loud	_____	3 = 4+ nights/week
My snoring affects people when I am sleeping away from home	_____	TOTAL = _____

Please list the main reason(s) you are seeking treatment for snoring or sleep apnea:

_____

Do you have other complaints?

- ☐ Frequent snoring
- ☐ Excessive Daytime Sleepiness (EDS)
- ☐ Difficulty falling asleep
- ☐ Waking up gasping / choking
- ☐ Morning headaches
- ☐ Neck or facial pain
- ☐ I have been told I stop breathing when I sleep
- ☐ Other: _____
- ☐ Difficulty maintaining sleep
- ☐ Choking while sleeping
- ☐ Feeling unrefreshed in the morning
- ☐ Memory problems
- ☐ Impotence
- ☐ Nasal problems, difficulty breathing through nose
- ☐ Irritability or mood swings

Subjective Signs and Symptoms

Rate your overall energy level (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Rate your sleep quality (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Have you been told you snore? YES / NO / SOMETIMES

Rate the sound of your snoring (Quiet) 1 2 3 4 5 6 7 8 9 10 (Loud)

On average, how many times per night do you wake up? _____

On average, how many hours of sleep do you get per night? _____

How often do you awaken with headaches? NEVER / RARELY / SOMETIMES / OFTEN / EVERYDAY

Do you have a bed partner? YES / NO / SOMETIMES **Do you sleep in the same room?** YES / NO

How many times per night does your bedtime partner notice you stop breathing?

SEVERAL TIMES PER NIGHT / ONCE PER NIGHT / SEVERAL TIMES PER WEEK / OCCASIONALLY / SELDOM / NEVER

Have you ever had a sleep study? YES NO
If YES, where and when? _____ **Date:**_____

Have you tried CPAP? YES NO
Are you currently using CPAP? YES NO
If YES, how many nights per week do you wear it? _____/ 7 Nights
When you wear your CPAP, how many hours per night do you wear it? _____hours per night

If you use or have used CPAP, what are your chief complaints about CPAP?

- ☐ Mask leaks
- ☐ An inability to get the mask to fit properly
- ☐ Discomfort from the straps or headgear
- ☐ Decrease sleep quality or interrupted sleep from CPAP device
- ☐ Noise from the device disrupting sleep and/or bedtime partner's sleep
- ☐ CPAP restricted movement during sleep
- ☐ CPAP seems to be ineffective
- ☐ Device causes teeth or jaw problems
- ☐ A latex allergy
- ☐ Device causes claustrophobia or panic attacks
- ☐ An unconscious need to remove CPAP at night
- ☐ Caused GI / stomach / intestinal problems
- ☐ CPAP device irritated my nasal passages
- ☐ Inability to wear due to nasal problems
- ☐ Causes dry nose or dry mouth
- ☐ The device causes irritation due to air leaks
- ☐ Other:

_____
_____

Are you currently wearing a dental device? YES NO
Have you previously tried a dental device? YES NO
If YES, was it Over the Counter (OTC)? YES NO
Was it fabricated by a dentist? YES NO **If YES, who fabricated it?** _____

If applicable, please describe your previous dental device experience:
_____

Have you ever had surgery for snoring or sleep apnea? YES NO

Please list any nose, palatal, throat, tongue, or jaw surgeries you have had.

DATE: _____ SURGEON: _____ SURGERY: _____
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DATE: _____ SURGEON: _____ SURGERY: _____

Please comment about any other therapy attempts (weight loss, gastric bypass, etc.) and how each impacted your snoring and apnea and sleep quality.
_____
_____
_____

Patient Signature: _____