Initial Sleep Screening

ELLIS K. LIST, D.D.S., P.A.
COMPREHENSIVE & ESTHETIC DENTISTRY

Patient Name (PRINT) _____

Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:
0=NEVER, 1=SLIGHT, 2=MODERATE, 3=HIGH - CIRCLE ONE RESPONSE FOR EACH QUESTION

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting in a public place	0	1	2	3
As a passenger in a car for one hour	0	1	2	3
Driving a car stopped for a few minutes in traffic	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting down quietly after lunch without alcohol	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3

Total Score: _____

Section 2: Subjective Sleep Evaluation

Please circle one "YES" or "NO" response for each statement or question

	NO	YES
Do you snore?	0	1
You, or your spouse, would consider your snoring louder than a person talking.	0	1
Your snoring occurs almost every night.	0	1
Your snoring is bothersome to your bed partner	0	1
Do you feel that in some way your sleep is not refreshing or restful?	0	1
Do you wake up at night or in the mornings with headaches?	0	1
Do you experience fatigue during the day, and have difficulty staying awake?	0	1
Do you have trouble remembering things, or paying attention during the day?	0	1
Do you have high blood pressure?	0	1

Total Score: _____

NOTES: In the space below, please add any additional information you would like the doctor to know regarding your snoring, sleep patterns or sleep apnea.

Patient Signature: _____ Date: _____/_____/_____

OFFICE USE ONLY

Epworth Sleepiness Scale ≥ 8? _____ Subjective Sleep Evaluation ≥ 3? _____