All About Smile Dental Group

Name:	DOB:	Date:

This questionnaire was developed based upon the published findings 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.

Y/ N	8	Have you 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 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 you snore ?
Y/N	2	Have you had 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 you legs while sleeping?
Y/N	3	Do you feel burning, tingling or crawling sensation 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?
TOTAL SCORE:		

FOR CLINICAL USE ONLY

LOW	MODERATE	HIGHT	SEVERE
0-7	8-11	12-15	16+

Visual Indications:

☐ Enlarged/Scalloped Tongue ☐ Retruded Lower Jaw ☐ High Arching Hard Palate ☐ Bruxism

☐ Gastro esophageal Reflux ☐ Enlarged Tonsils ☐ Mouth Breather

Have you ever been diagnosed with a sleep disorder? ☐ Yes ☐ No

Are you currently using a CPAP machine? ☐ Yes ☐ No

Notes: