Tranquil Sleep Solution - Sleep Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

** = filled by provider/hygienist

First Name	Middle Initial	Last Name	Tally ARES Risk Points

Weight	Pounds	**Age**	Years	Gender	Male ◯ Female ◯
Height	Feet / Inches		**Neck Size**	Inches	
Date of Birth	Month / Day / Year		**Mallampati Class** 1 / 2 / 3 / 4	**Scalloped Tongue:** Y / N	

Neck Size
+2 if Male >16.5
+2 if Female>15.0

Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Heart disease	Yes ☐	No ☐	Depression	Yes ☐	No ☐
	☐	☐		Yes ☐	No ☐
Lung disease	Yes ☐	No ☐	Nasal oxygen use	Yes ☐	No ☐
Insomnia	Yes ☐	No ☐	Restless leg syndrome	Yes ☐	No ☐
Narcolepsy	Yes ☐	No ☐	Morning Headaches	Yes ☐	No ☐
Sleeping Medication	Yes ☐	No ☐	Pain Medication e.g.,Vicodin, oxycontin	Yes ☐	No ☐

Co-morbidities +1 for each Yes re spon se

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting, inactive, in a public place (theater, meeting, etc)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Epworth Score **TOTAL** the values from all 8 questions, If 11 or less, **Score=0** If 12 or more, **Score=2**

Score

Assign points for each of the first three responses

Frequency	**0 - 1 times/week**	**1 - 2 times/week**	**3 - 4 times/week**	**5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?

Never ☐ Rarely ☐ +1 Sometimes ☐ +2 Frequently ☐ +3 Almost always ☐ +4

Do you wake up choking or gasping?

Never ☐ Rarely ☐ +1 Sometimes ☐ +2 Frequently ☐ +3 Almost always ☐ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never ☐ Rarely ☐ +1 Sometimes ☐ +2 Frequently ☐ +3 Almost always ☐ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always ☐

Signature	Today's Date	Phone Number	**Total all 6 boxes from above**	**Point Total**
	___/___/___		**If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)**	

Email Address: