Oakridge Dental Center

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

PATIENT DEMOGRAPHICS		
Last	First	Middle Initial
Date of Birth	○ Male ○ Female	ID# Optional
Height _____feet _____inches	Weight _____pounds	Neck Size _____inches

MEDICAL CONDITIONS: 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
Diabetes	○ Yes ○ No	Sleep Apnea	○ Yes ○ No
Lung Disease	○ Yes ○ No	Nasal oxygen use	○ Yes ○ No
Insomnia	○ Yes ○ No	Restless legs syndrome	○ Yes ○ No
Narcolepsy	○ Yes ○ No	Morning headaches	○ Yes ○ No
Sleep Medication	○ Yes ○ No	Pain Medication	○ Yes ○ No

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

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

HABITS	Never	Rarely 0-1 times/wk	Sometimes 1-2 times/wk	Frequently 3-4 times/wk	Always 5-7 times/wk
On average in the past month, how often have you snored or been told that you snore?	○ +0	○ +1	○ +2	○ +3	○ +4
Do you wake up choking or gasping?	○ +0	○ +1	○ +2	○ +3	○ +4
Have you ever been told that you stop breathing in your sleep or wake up choking or gasping?	○ +0	○ +1	○ +2	○ +3	○ +4
Do you have problems keeping your legs still at night or need to move them to feel comfortable?	○ +0	○ +0	○ +0	○ +0	○ +0

I have personally completed this questionnaire. **By signing this agreement,** you acknowledge that you have read, understand, and agree to the terms and conditions of the Patient Authorization form on the reverse side of this form.

Patient Signature_____ Date_____

Patient Phone Number_____