Dr. Dick Dykman

Bullmoose Orthodontics
2480 W. Ray Rd. Ste 2 Chandler, AZ 85224
(480)782-1200

Adult Sleep Assessment and Epworth Scale

Patient Name: _____ Today's Date: _____

Date of birth: _____ Age: _____ Height: _____ Weight: _____

Please list any medical problems within the last 5 years (hypertension, diabetes, surgery, etc.)

_____

_____

Have you suffered a heart attack or stroke? _____ When? _____

Circle the appropriate response:

Do you snore at night?	Yes	No	Occasionally
Witnessed pauses in breathing while asleep?	Yes	No	Occasionally
Do you have difficulty falling asleep?	Yes	No	Occasionally
Do you have difficulty maintaining sleep?	Yes	No	Occasionally
Experience a restless sensation in legs while laying awake in bed?	Yes	No	Occasionally
Kicking and twitching movements while asleep?	Yes	No	Occasionally
Experience excessive daytime tiredness?	Yes	No	Occasionally
Have you ever awakened feeling paralyzed?	Yes	No	Occasionally
Experience a sudden loss of strength in your arms or legs?	Yes	No	Occasionally
If the previous answer is Yes, were these events brought on by a sudden, frightening event or laughter?	Yes	No	

Circle all that apply:
Do you frequently awaken with:

Dry Mouth	Nasal Congestion	Headache
Heartburn	Chest Pain	Excessive sweating
Choking & Gasping	Feeling groggy & unrefreshed	

According to the following scale choose the appropriate number value to represent how likely you are to fall asleep during the day in the following situations. Try to be as honest as possible. If possible have you significant other help you fill this portion out. **0- Never 1- Slight chance 2- Moderate 3-Always**

Sitting and reading	0	1	2	3
Watching T.V.	0	1	2	3
Sitting inactive in public (movie theater, meeting)	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Driving a vehicle for two or more hours	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3

TOTAL: _____