New Era Consulting
Specializing in Medical Billing for Dentists

Patient Name:

Patient DOB:

Date:

Epworth Sleepiness Scale Questionnaire

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.

1. Have you ever been told you stop breathing while asleep?	Y / N	8
2. Have you ever fallen asleep or nodded off while driving?	Y / N	6
3. Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y / N	6
4. Do you feel excessively sleepy during the day?	Y / N	4
5. Do you snore, or have you ever been told that you snore?	Y / N	4
6. Do you have trouble falling asleep?	Y / N	4
7. Do you have trouble staying asleep once you fall asleep?	Y / N	4
8. Do you kick or jerk your legs while sleeping?	Y / N	3
9. Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y / N	3
10. Do you wake up with headaches during the night or in the morning?	Y / N	3
11. Have you had weight gain and found it difficult to lose?	Y / N	2
12. Have you taken medication for, or been diagnosed with high blood pressure?	Y / N	2
Total Score		

For Doctor/Staff Use Only

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

Visual Indications

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

☐ Gastroesophageal Reflux ☐ Enlarged Tonsils ☐ Mouth Breather

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

Are you currently using a CPAP machine? Yes or No (if yes) Do you use it every night? Yes or No

Notes: