Barnes Dentistry, P.C

SLEEP

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situatons?

✓ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (i.e. a theater or a meeting)	☐	☐	☐	☐
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 quitely after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopping for a few minutes in traffic	☐	☐	☐	☐

Total Score: _____ *(Add columns 0-3)*

Patient Signature_____ Date _____ Page 1

CPAP Intolerance (Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it, please fill in this section (please circle those that apply):

Mask leaks
Inability to get the mask to fit properly
Discomfort from headgear
Disturbed or interrupted sleep
Noise disturbing sleep and/or bed partner's sleep
CPAP restricted movements during sleep
CPAP does not seem to be effective
Pressure on the upper lip causing tooth related problems
Latex allergy
Claustrophobic associations
An unconscious need to remove the CPAP
Does not resolve symptoms
Noisy
Cumbersome
Other_____

OTHER THERAPY ATTEMPTS (If appropriate)

What other therapies have you had for breathing disorders? (Please circle those that apply)

Dieting
Weight loss
Surgery (uvuloplasty)
Surgery (uvulectomy)
Pillar procedure
Smoking cessation
CPAP
BiPAP
Uvulectomy (but continue to have symptoms)
Uvuloplasty (but continue to have symptoms