BAYSIDE, NEW YORK
Bell Family Dental
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HomeSleep DENTAL

Dental Chairside Screener

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PATIENT INFORMATION:

Name: _____ Date: _____

1. Do you snore loudly or have been told that you snore?	YES ❑	NO ❑
2. Do you ever awaken with a sensation of gasping or choking?	YES ❑	NO ❑
3. Has anyone ever noticed that you stop breathing during your sleep?	YES ❑	NO ❑
4. Do you often wake up with a dry mouth?	YES ❑	NO ❑
5. Do you find your sleep to be non-refreshing?	YES ❑	NO ❑
6. Do you often feel tired, fatigued, or sleepy during daytime?	YES ❑	NO ❑
7. Do you ever fall asleep or nod off in situations where you did not intend to?	YES ❑	NO ❑
8. Do you have (or are being treated for) high blood pressure and/or diabetes?	YES ❑	NO ❑

If you answered **YES** to **3 or more** questions, you are a candidate for a Home Sleep Test to evaluate the presence of Obstructive Sleep Apnea.

**This questionnaire utilizes portions of the Berlin questionnaire, Epworth Sleepiness Scale (ESS), and STOP-BANG questionnaire, which are widely recognized by the AASM as diagnostic tools for obstructive sleep apnea (OSA).*

FAX COMPLETED FORM TO 855-967-1112