Mackie Dental Sleep Screening

Do you have morning headaches?	Y / N
Do you wake up tired?	Y / N
Do you gasp for breath at night?	Y / N
How long do you sleep at night?	_____ hrs
Are you currently wearing a C-PAP?	Y / N
Have you had a sleep study?	Y / N

Epworth Sleepiness Scale

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0=Would never dose **1=Slight chance of dozing**
2=Moderate chance of dozing **3=High chance of dozing**

SITUATION	
Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (i.e. in theater)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
TOTAL SCORE	_____

A score of 8 or greater indicates the possibility of sleep disordered breathing.

Thornton Snoring Scale

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her both physically and emotionally. Use the following scale to choose the most appropriate number for each situation (Go to the 4th statement if you have no bed partner)

0=Never **1=Infrequently (1 night per week)**
2=Frequently (2-3 nights per week) **3=Most of the time (4 or more nights per week)**

My snoring affects my relationship with my partner	_____
My snoring causes my partner to be irritable or tired	_____
My snoring requires us to sleep in separate rooms	_____
My snoring is loud	_____
My snoring affects people when I am sleeping away from home (hotel, camping , etc.)	_____
TOTAL SCORE	_____

A score of 5 or greater indicates your snoring may be significantly affecting your quality of life.

Patient Name _____ Date: _____