ProHEALTH Dental™
Affiliate of Northwell Health®

Annual Medical Questionnaire for Sleep Disorders

At ProHEALTH Dental, we care about your overall health and well-being. It is well-documented that certain oral health problems are related to many chronic diseases and can affect how you eat, sleep and live. Please complete this questionnaire so we can help you be the healthiest you.

Name _____

Height _____ Weight _____ Age _____ Male / Female _____Date _____

Have you been diagnosed with Sleep Apnea before and received treatment?	☐ YES	☐ NO
If you answered "YES" to the above question, please STOP and hand the questionnaire to a staff member.		

PATIENT RESPONSES		
STOP		
Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed door)?	YES	NO
Do you often feel **TIRED**, fatigued, or sleepy in the daytime?	YES	NO
Has anyone **OBSERVED** you stop breathing during your sleep?	YES	NO
Do you have-or are you being treated for high blood **PRESSURE**?	YES	NO
TOTAL:		

BANG		
BMI higher than 35kg/m2?	YES	NO
AGE over 50 years old?	YES	NO
NECK circumference greater than 16 inches (40cm)?	YES	NO
GENDER: MALE?	YES	NO
TOTAL:		

	YES	NO
TOTAL SCORE:		

High risk of OSA: Yes 5 – 8 **Intermediate risk of OSA: Yes 3 – 4** **Low risk of OSA: Yes 0 - 2**

For internal use only: **Discussed with patient:** YES NO Hygienist name _____Date: _____

Circle the code below based on findings and record in Dentrix at the time of visit:

E0008: Sleep questionnaire form administered **HYG initials _____**

E0000: Positive sleep questionnaire form (if two or more answers are YES) **HYG initials _____**

E0006: Refer for sleep consultation/ home test/physician **HYG initials _____**

Patient is in active treatment: YES NO **Patient is interested in consultation: YES NO**

If two or more "YES" answers, schedule complimentary sleep consultation at ProHEALTH Dental.

This form must be scanned into patient's Document center.