CELEBRATION DENTAL GROUP

ProAct Health Solutions

Today's Date:__________________

Screening Questionnaire

First Name | Middle Name | Last Name | DOB

Billing/Street Address | City | State | Zip

Cell Phone | Home Phone | Email

Medical Insurance Policy#

Communication Preference: [Check one] ☐ Text ☐ email

Physical Basics

☐ Male ☐ Female Height: _____ft. _____in. Weight_______lb. Waist: _____in. Neck: _______in.

Medical History

Have you been diagnosed with any of the following conditions?

High Blood Pressure	☐Yes ☐ No	Narcolepsy	☐Yes ☐ No
Heart Disease	☐Yes ☐ No	Restless Leg Symptom	☐Yes ☐ No
Vascular Disease	☐Yes ☐ No	Morning Headache	☐Yes ☐ No
Diabetes	☐Yes ☐ No	Frequent Night Urination	☐Yes ☐ No
Stroke	☐Yes ☐ No	Migraine	☐Yes ☐ No
Depression	☐Yes ☐ No	Asthma	☐Yes ☐ No
Insomnia	☐Yes ☐ No	Sleep Apnea	☐Yes ☐ No
Nasal Oxygen	☐Yes ☐ No	Sleep Medication	☐Yes ☐ No
CPAP	☐Yes ☐ No	Pain Medication	☐Yes ☐ No
Do you smoke?	☐Yes ☐ No	Chronic Pain	☐Yes ☐ No
Years? _____ Packs/Day? __________		Location: Back□ Leg□ Other: _________	
Happy CPAP user?	☐Yes ☐ No		

Do you have any of these Symptoms?

	Yes	No
1. Have you been told, or are you aware, that you snore loudly?	☐Yes	☐ No
2. Do you sometimes wake up choking or gasping?	☐Yes	☐ No
3. Have you been told that you stop breathing, or have pauses in your breathing, during your sleep?	☐Yes	☐ No
4. Do you wake up suddenly, for no reason, from your sleep?	☐Yes	☐ No
5. Do you have periods of the day when you have trouble paying attention, remembering things, or staying awake?	☐Yes	☐ No
6. Do you feel that in some way your sleep is not refreshing or restful?	☐Yes	☐ No
7. Do you often feel tired, fatigued, or sleepy during daytime?	☐Yes	☐ No

How Sleepy/Tired Are You?

Almost one-third of your life should be spent in restful sleep. Being sleepy or tired effects how you think, how you feel, how you function, and your overall health. Your quality of life depends on quality sleep. When answering the questions below you should consider both how likely you are to doze and also your overall level of fatigue.

Use the following scale to choose the most appropriate number for each situation.

O = Would never doze 2 = Moderate chance of dozing

1 = Slight chance of dozing 3 = High chance of dozing

What is the probability that you will face a chance of Dozing in the following situations?

Please check the appropriate choice using the scale above	Never	Slight	Moderate	High
1. Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
2. Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
3. Sitting inactive in a public place (for example, at a theatre or in a meeting)	☐ 0	☐ 1	☐ 2	☐ 3
4. As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
5. Lying down to rest in the afternoon when circumstances permit	☐ 0	☐ 1	☐ 2	☐ 3
6. Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
7. Sitting quietly after a lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
8. In a car while stopped for a few minutes in the traffic	☐ 0	☐ 1	☐ 2	☐ 3

For Clinical Use:

Epworth Score	
STOP	
BANG	
STOP/BANG	
Screening Status	
Consultation Date	
Assessment Status	

Dr. Figueroa__________________

Dr. McDaniel__________________

Dr. Orlando__________________

PT ID #_______________________