CROSSINGS CLINIC
dental sleep apnea center

LOUISVILLE DENTAL
SLEEP MEDICINE, PLLC

Progress Questionnaire

Patient Name: _____

Date: _____

Office Use Only:
Type of Device: _____
Titration: _____

On average, how many nights per week are you wearing your device? ☐

EPWORTH SLEEPINESS SCALE ***(Rate as 0-3 per scale at right)***

Sitting and reading	
Watching TV	
Sitting inactive in a public place	
As a car passenger for an hour without break	
Lying down in afternoon to rest	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car while stopped at a traffic light	
TOTAL	

0=Never
1=Slight Chance
2=Moderate Chance
3=High Chance

THORNTON SNORING SCALE ***(Rate as 0-3 per scale at right)***

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 away from home	
TOTAL	

0=Never
1=1 night/week
2=2-3 nights/week
3=4 or more nights/week

Rate your snoring level TODAY *(0=no snoring, 10=very loud snoring)* _____

Rate your energy level TODAY *(0=very tired, 10=very energetic)* _____

Rate your sleep quality TODAY *(0=very poor, 10=very good)* _____

How often do you have morning headaches? *(circle one)* Never Daily Weekly Monthly

How many times are you waking per night? *(times per night)* _____

Does your bedtime partner notice you stop breathing? *(number of times per night)* _____

Average hours of sleep per night: _____

Comments *(Other sleep related information)* _____

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