Avelle ORTHODONTICS

ADULT SLEEP AND HEALTH QUESTIONNAIRE
(ASHQ)

Patient Name: _____ **Date:** _____

BREATHING

Do you breathe through your mouth during the day? ☐ No ☐ Yes

If yes, how often? ☐ Occasionally ☐ Frequently ☐ Always

Do you breathe through your mouth while sleeping? ☐ No ☐ Yes

If yes, how often? ☐ Occasionally ☐ Frequently ☐ Always

NIGHTTIME SYMPTOMS & SLEEP POSITION

Do you wake up with a dry mouth? ☐ No ☐ Yes

Do you wake up with a sore throat? ☐ No ☐ Yes

Do you toss and turn at night? ☐ No ☐ Yes

If yes, how often? ☐ Occasionally ☐ Frequently ☐ Always

Do your arms or legs jerk during sleep? ☐ No ☐ Yes

If yes, severity: ☐ Mild ☐ Moderate ☐ Severe

Do you grind or clench your teeth? ☐ No ☐ Yes ☐ Not sure

If yes: ☐ Night ☐ Day ☐ Both

How would you rate your sleep quality? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What position do you typically sleep in? ☐ Back ☐ Side ☐ Stomach ☐ Other: _____

MEDICAL HISTORY

Have you been diagnosed with Sleep Apnea? ☐ No ☐ Yes

If yes, when diagnosed? _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Have you had a sleep study? ☐ No ☐ Yes

If yes, please provide a copy of the report.

Have you had any surgeries related to sleep apnea? ☐ No ☐ Yes

If yes, please list: _____

Do you smoke? ☐ No ☐ Yes

If yes — Packs/day: _____ Cigarettes/day: _____ Years: _____

Do you have any lung or pulmonary conditions? ☐ No ☐ Yes

If yes, please specify: _____

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EPWORTH SLEEPINESS SCALE

(ESS)

The ESS measures how likely you are to doze off or fall asleep in the following situations, in contrast to feeling just tired. This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:
0 = would never doze; 1 = slight chance of dozing; 2 = moderate chance of dozing; 3 = high chance of dozing

It is important that you answer each question as best you can.

Situation	*Chance of Dozing* (circle one)			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (eg, a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total Score: _____

Interpretation

0–5	Normal
6–10	Higher Normal
11–12	Mild excessive sleepiness
13–15	Moderate excessive sleepiness
16–24	Severe excessive sleepiness

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NASAL OBSTRUCTION SYMPTOM EVALUATION

N.O.S.E. Score

Please help us better understand the impact of nasal obstruction on your quality of life by completing the below. Over the past **4 weeks**, how much of a **problem** were the following symptoms for you?

Please mark the most correct response	*Not a Problem* 0	*Mild Problem* 1	*Moderate Problem* 2	*Fairly Bad Problem* 3	*Severe Problem* 4
Nasal Congestion or Stuffiness	◯	◯	◯	◯	◯
Nasal Blockage or Obstruction	◯	◯	◯	◯	◯
Trouble Breathing Through My Nose	◯	◯	◯	◯	◯
Trouble Sleeping	◯	◯	◯	◯	◯
Unable to Get Enough Air Through My Nose During Exercise or Exertion	◯	◯	◯	◯	◯

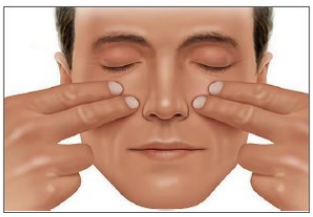
Does the Cottle Maneuver help you breathe better?

Follow the steps pictured here.

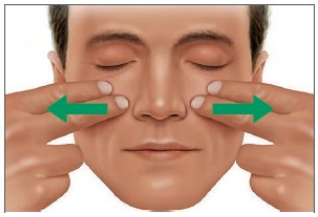
◯ YES ◯ NO

Do you use nasal strips during activity or sleep?

◯ YES ◯ NO



Step 1: Place two finger tips on your cheeks, on each side of your nose.



Step 2: Gently press and pull outward. Breathe through your nose.

Sum the answers the patient marked and multiply by 5 to base scale out of a possible score of 100.

Symptoms Total _____

Multiply total by 5 and enter below.

Patient's N.O.S.E. Score _____

5–25	Mild Obstruction
30–50	Moderate Obstruction
55–75	Severe Obstruction
80–100	Extreme Obstruction

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STOP-BANG QUESTIONNAIRE

Sleep Apnea Screening Tool

Answer Yes or No for each question:

STOP

S	**Snoring –** Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	☐ Yes	☐ No
T	**Tired –** Do you often feel tired, fatigued, or sleepy during the daytime?	☐ Yes	☐ No
O	**Observed apnea –** Has anyone observed you stop breathing during your sleep?	☐ Yes	☐ No
P	**Pressure –** Do you have or are you being treated for high blood pressure?	☐ Yes	☐ No

BANG

B	**BMI –** Is your Body Mass Index greater than 35?	☐ Yes	☐ No
A	**Age –** Are you older than 50 years old?	☐ Yes	☐ No
N	**Neck circumference –** Is your neck circumference greater than 17 inches (43 cm) for males and 16 inches (41 cm) for females?	☐ Yes	☐ No
G	**Gender –** Are you male?	☐ Yes	☐ No

Interpretation

Each Yes = 1 point **Score:** _____

0–2 Low Risk
3–4 Intermediate Risk
5–8 High Risk

Score ≥ 3 = positive screening for sleep apnea risk

Body Mass Index Table

Height		Weight in Pounds													
4-10	→	91	96	100	105	110	114	120	124	129	134	139	143	167	191
4-11	→	94	99	104	109	114	119	124	129	133	138	143	148	173	198
5-0	→	97	102	108	112	118	123	128	133	138	143	149	153	179	204
5-1	→	100	106	111	116	122	127	132	137	143	148	153	158	185	211
5-2	→	104	109	115	120	126	131	136	142	147	153	158	164	191	218
5-3	→	107	113	118	124	130	135	141	147	152	156	163	169	197	225
5-4	→	111	116	122	128	134	140	145	151	157	163	168	174	204	233
5-5	→	114	120	126	132	138	144	150	153	162	168	174	180	210	240
5-6	→	118	124	130	136	142	148	155	161	167	173	179	185	216	248
5-7	→	121	127	134	140	147	153	159	166	172	178	185	191	223	255
5-8	→	125	131	138	144	151	158	164	171	177	187	190	197	230	263
5-9	→	128	135	142	149	155	162	169	176	183	189	196	203	237	270
5-10	→	132	139	146	153	160	167	174	181	188	195	202	209	249	278
5-11	→	136	143	150	157	165	172	179	186	193	200	208	215	250	286
6-0	→	140	147	155	162	169	177	184	191	199	206	213	221	258	294
6-1	→	144	151	159	166	174	182	190	197	204	212	219	227	268	303
6-2	→	148	155	163	171	179	187	194	202	210	218	225	233	272	311
6-3	→	152	160	168	176	184	192	200	208	216	224	232	240	279	319
6-4	→	156	164	172	180	189	197	205	213	221	230	238	246	287	328
		↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
		19	20	21	22	23	24	25	26	27	28	29	30	35	40
		BMI													

1. Look down the left column to find patient's height in feet and inches.
2. In the same row, find the number closest to the patient's weight in pounds.
3. BMI appears at the bottom of the column below the patient's weight.

Note: To calculate BMI with kilograms and meters use this formula: BMI = weight (kg)/height (m^2)