Briggs Family & Cosmetic Dentistry
6920 E. Shea Blvd. #201
Scottsdale, AZ 85254

Sleep Disorders Breathing Screening

Patient Name: _____ ***Date:***_____
DOB: _____ Gender: M F

Have you been told you snore?	Yes _____	No _____
Do you ever choke or gasp while you sleep?	Yes _____	No _____
Do you feel tired, fatigued or sleepy during the day?	Yes _____	No _____
Do you experience chronic nasal congestion?	Yes _____	No _____
Do you have high blood pressure?	Yes _____	No _____
Do you have acid reflux/GERD?	Yes _____	No _____
Have you had an overnight sleep study?	Yes _____	No _____
If yes, approximate date _____		
Do you have a CPAP?	Yes _____	No _____
If yes, do you use your CPAP nightly? ____ Yes ____No		

For Staff Use

Physical Exam: (indicate all that are present)
_____ Large Tonsils
_____ Scalloped/Large Tongue
_____ Narrow Palate Mallampati Score: _____

Additional Notes:_____
_____

____Patient appears to have minimal risk of Sleep Disorders Breathing ***DOCTOR Initials:***_____

Recommended Next Steps

___ Diagnostic Sleep Test ___ Oral Appliance Consultation ___ Referral to Specialist
___ Educational Brochures given to patient
___ Informational Resources Handout given to patient
___ Gave patient information on Snore Lab app for phone

Notes: