EPWORTH SLEEPINESS SCALE

Name_____ DOB_____

Date _____ Gender_____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

Even if you have not done some of these things in the last month, try to imagine 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 as you can.*****

Situation	**Chance of dozing** (out of 3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (eg. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
	Total out of 24

Score Interpretation:

(1-10) Normal Range (10--16) Excessively sleepy (16-24) Abnormally sleepy

Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____ yes _____no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____yes _____no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____yes _____no

Are you happy with your CPAP or Sleep Appliance? _____yes _____no

If you are not happy - why? _____

_____

_____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosted with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = $\frac{\text{(your weight in pounds X 703)}}{\text{(your height in inches X your height in inches}}$

ADVANCED DENTAL ARTS NW

Berlin Questionnaire©

Sleep Apnea

Height (ft) _____ Weight (lbs) _____ Age _____ Gender assigned at birth: Male/female

Please choose the correct response for your experience to each question.

Category 1

1. Do you snore?
   a. Yes
   b. No
   c. Don't know

   If you answered 'yes':
2. Your snoring is:
   a. Slightly louder than breathing
   b. As loud as talking
   c. Louder than talking

3. How often do you snore?
   a. Almost every day
   b. 3-4 times per week
   c. 1-2 times per week
   d. 1-2 times per month
   e. Rarely or never

4. Has your snoring ever bothered other people?
   a. Almost every day
   b. 3-4 times per week
   c. 1-2 times per week
   d. 1-2 times per month
   e. Rarely or never

5. Has anyone noticed that you stop breathing during your sleep?
   a. Almost every day
   b. 3-4 times per week
   c. 1-2 times per week
   d. 1-2 times per month
   e. Rarely or never

Category 2

6. How often do you feel tired or fatigued after your sleep?
   a. Almost every day
   b. 3-4 times per week
   c. 1-2 times per week
   d. 1-2 times per month
   e. Rarely or never

7. During your waking time, do you feel tired, fatigued or not up to par?
   a. Almost every day
   b. 3-4 times per week
   c. 1-2 times per week
   d. 1-2 times per month
   e. Rarely or never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
   a. Yes
   b. No

   If you answered 'yes':
9. How often does this occur?
   a. Almost every day
   b. 3-4 times per week
   c. 1-2 times per week
   d. 1-2 times per month
   e. Rarely or never

Category 3

10. Do you have High blood pressure?
    a. Yes
    b. No
    c. Don't know

How to score the Berlin Questionnaire

The questionnaire consists of 3 categories related to the risk of having sleep apnea. Patients can be classified into High Risk or Low Risk based on their responses to the individual items and their overall scores into the symptom categories.

Categories and Scoring:
Category 1: items 1, 2, 3, 4, and 5;
Item 1: if **'yes'**, assign **1 point**
Item 2: if **'c'** or **'d'** is the response, assign **1 point**
Item 3: if **'a'** or **'b'** is the response, assign **1 point**
Item 4: if **'a'** is the response, assign **1 point**
Item 5: if **'a'** or **'b'** is the response, assign **2 points**
Add points. *Category 1 is positive if the total score is 2 or more points.*

Category 2: items 6, 7, 8 (item 9 should be noted separately).
Item 6: if **'a'** or **'b'** is the response, assign **1 point**
Item 7: if **'a'** or **'b'** is the response, assign **1 point**
Item 8: if **'a'** is the response, assign **1 point**
Add points. *Category 2 is positive if the total score is 2 or more points.*

Category 3 is positive if the answer to item 10 is **'Yes'** or if the BMI of the patient is greater than 30kg/m2.
(BMI is defined as weight (kg) divided by height (m) squared, i.e.., kg/m2).

High Risk: if there are 2 or more categories where the score is positive.

Low Risk: if there is only 1 or no categories where the score is positive.

Additional Question: item 9 should be noted separately.

Name:_____ Date:_____

HEADACHE IMPACT TEST™

Please circle the response that best describes how you feel and calculate the totals below.

1. **When you have headaches, how often is the pain severe?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always

2. **How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always

3. **When your have a headache, how often do you wish you could lie down?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always

4. **In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?**

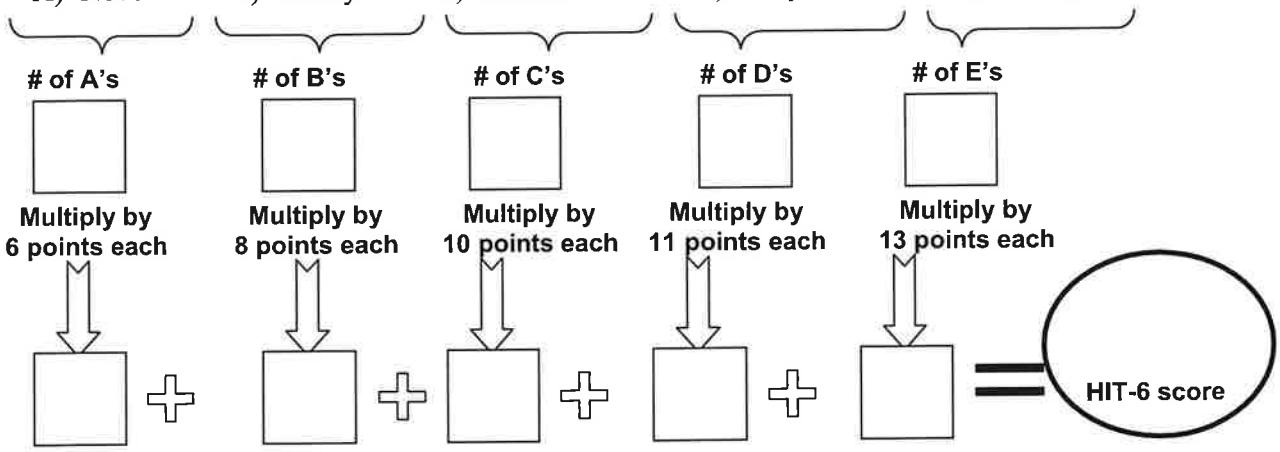
A) Never B) Rarely C) Sometimes D) Very Often E) Always

5. **In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always

6. **In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always



Bonus Questions

On a scale of 0-10, with "10" being the worst discomfort imaginable above the shoulders, and a "0" is no pain at all (you feel fabulous), how many mornings per week do you wake with a "0", that is, *you feel fabulous?*_____

On those mornings that you wake "with a number", what's the average number that you have? _____

HEADACHE IMPACT TEST™

What Does Your Score Mean?

If You Scored 60 or More

Your headaches are having a very severe impact on your life. You may be experiencing disabling pain and other symptoms that are more severe than those of other headache sufferers. Don't let your headaches stop you from enjoying the important things in your life, like family, work, school or social activities.

Make an appointment **today** to discuss your HIT-6 results and your headaches with your doctor.

If You Scored 56 – 59

Your headaches are having a substantial impact on your life. As a result you may be experiencing severe pain and other symptoms, causing you to miss some time from family, work, school, or social activities.

Make an appointment **today** to discuss your HIT-6 results and your headaches with your doctor.

If You Scored 50 – 55

Your headaches seem to be having some impact on your life. Your headaches should not make you miss time from family, work, school, or social activities.

Make sure you discuss your HIT-6 results and your headaches at your next appointment with your doctor.

If You Scored 49 or Less

Your headaches seem to be having little to no impact on your life at this time. We encourage you to take HIT-6 monthly to continue to track how your headaches affect your life.

If Your Score on HIT-6 is 50 or Higher

You should share the results with your doctor. Headaches that are disrupting your life could be migraine.

Take HIT-6 with you when you visit your doctor because research shows that when doctors understand exactly how badly headaches affect the lives of their patients, they are much more likely to provide a successful treatment program, which may include medication.

HIT is also available on the Internet at www.headachetest.com.

The Internet version allows you to print out a personal report of your results as well as a special detailed version for your doctor.

Don't forget to take HIT-6 again or try the Internet version to continue to monitor your progress.

About HIT

The Headache Impact Test (HIT) is a tool used to measure the impact headaches have on your ability to function on the job, at school, at home and in social situations. Your score shows you the effect that headaches have on normal daily life and your ability to function. HIT was developed by an international team of headache experts from neurology and primary care medicine in collaboration with the psychometricians who developed the SF-36®* health assessment tool.

HIT is not intended to offer medical advice regarding medical diagnosis or treatment. You should talk to your healthcare provider for advice specific to your situation.

SF-36® is a registered trademark of Medical Outcomes Trust and John E. Ware, Jr.

HIT-6 Scoring Interpretation English Version 1.1