A CENTER FOR DENTAL MEDICINE

GENERAL DENTIST UTILIZING
LASER DENTISTRY   DIGITAL RADIOGRAPHY   ORTHODONTICS
NON-SURGIVCAL GUM TREATMENT   SLEEP APNEA TREATMENT

Sleep Observer Scale

PATIENT NAME ____

OBSERVER NAME ____

DATE
This questionnaire asks questions about behaviors that you have observed in this patient in various situations. Your observations do not need to be a single night's behavior, it is better to indicate a summary or average of behaviors you've observed over multiple nights.

Choose the appropriate score or frequency for each situation.

0 = Never
1 = Infrequently
2 = Frequently
3 = Very Regularly

1. Very loud irritating snoring

2. Snoring requiring separate bedrooms

3. Choking or gasping during sleep

4. Pauses in breathing during sleep

5. Waking up during sleep frequently

6. Restless tossing and turning

7. Twitching / Kicking of arms or legs

8. Excessive sleepiness during the day (Falling asleep
   easily or in inappropriate situations)