# DST PROGRESS QUESTIONNAIRE FOR DENTAL SLEEP THERAPY

Patient Name: _____

Today's Date: _____

Type of Device: _____

Titration: _____
**Office use only*

On average how many nights per week are you wearing your device? _____ nights/week.
*(Fill in blank 0 – 7)*

## EPWORTH SLEEPINESS SCALE

| | |
|---|---|
| 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 w/out 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

| | |
|---|---|
| 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

1. Rate your snoring level TODAY *(0-10)*: _____*(0 = no snoring / 10 = very loud snoring)*
2. Rate your energy level TODAY (*0-10)*: _____*(0 = very tired / 10 = very energetic)*
3. Rate your sleep quality TODAY *(0 – 10)*: _____*(0 = very poor / 10 = very good)*
4. How often do you have morning headaches? never / daily / weekly / monthly *(circle one)*
5. How many times are you waking per night? _____times per night.
6. My bedtime partner notices me stop breathing _____times per night.
7. Average Hours of sleep per night: _____hours per night.
8. Comments *(Other sleep related information)* _____