Center for Cosmetic, Implant & Neuromuscular Dentistry

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name		Tally ARES Risk Points
Weight	Pounds	**Age**	Years	Gender **Male** ○ **Female** ○	
Height	Feet	Inches	**Neck Size**	Inches	Neck Size +2 Male ≥16 5 +2 Female≥15.0
Date of Birth	Month / Day / Year		**ID Number**	Optional	Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
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 lunch without alcohol				
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score **TOTAL** the values from all 8 questions, If 11 or less **Score = 0** If 12 or more **Score = 2**

Score

Frequency **0 - 1 times/week** **1 - 2 times/week** **3 - 4 times/week** **5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?

Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?

Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Assign points for each of the first three responses

Signature	Area Code / Phone Number	**Total all 6 boxes from above** **If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)**	**Point Total**

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Bed Partner Questionnaire

To be completed by the Patient's bed partner, without influence of the Patient. Please complete and have the Patient bring with them to their sleep study appointment.

Patient's Name:_____ Date: _____
Relationship to Patient: _____

Please estimate how many hours of sleep your bed partner gets:

Sleep Schedule:	Hours Each Night:	How Long does it take to fall asleep?	How long is your partner awake during the night?
Work Days:			
Days Off:			

Mark any positions your bed partner sleeps in: ☐ Back ☐ Side ☐ Stomach

Does your bed partner snore? ☐ Never ☐ Occasionally ☐ Often ☐ Unknown
If they snore, please mark the positions they snore in: ☐ Back ☐ Side ☐ Stomach

How loud is his/her snoring? ☐ 1 (Light) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Loud)

Does your bed partner do any of the following in his/her sleep? (Please mark all that apply)
☐ Gagging ☐ Choking ☐ Snorting ☐ Gasping ☐ Teeth Grinding ☐ Kicking their feet

	Never	Occasionally	Often	Unknown
Does you bed partner take naps during the day?				
Does your partner stop breathing in his/her sleep?				
Does your bed partner fall asleep when driving?				
Does he/she fall asleep without warning?				
Does your bed partner kick their legs while sleeping?				
Does your bed partner mumble. talk. or yell during sleep?				

Does your bed partner awaken during the night? ☐ Never ☐ Occasionally ☐ Often ☐ Unknown
If they awaken, how long does it take them to get back to sleep? Hrs:____ Mins: ___ ☐ Unknown
Do you know why he/she awakens? ☐ Yes ☐ No If yes, Why? _____
_____

Is you bed partner restless during sleep? ☐ Never ☐ Occasionally ☐ Often ☐ Unknown
Describe what they do when restless: _____
_____
_____

How much stress does your bed partner currently have? D 1 (Light) D 2 D 3(A Lot) D Unknown

Please estimate your bed partner's risk of falling asleep or dozing off in the following situations, using the following scale: 0 = No chance 1= Slight chance 2= Moderate chance 3= High chance

Sitting and reading: D O D 1 D 2 D 3	Lying down to rest in the afternoon: D O D 1 D 2 D 3
Watching TV : D O D 1 D 2 D 3	As a passenger in a car, for an hour, with no break : D O D 1 D 2 D 3
Sitting, inactive, in public (Theater, Meetings, Etc,) : D O D 1 D 2 D 3	Sitting quietly after lunch, without Alcohol: D O D **1** D 2 D 3
Sitting and talking to someone: D O D I D 2 D 3	In a car, stopped in traffic, for a few minutes: D O D 1 D 2 D 3

Has your bed partner's mood, memory, concentration, or personality deteriorated or changed?
D Yes D No If yes, please explain: _____

_____

_____

Does your bed partner's sleep problems disrupt your sleep? D Never D Occasionally D Often
Explain: _____

_____

Please use this space for any other information you would like to add.

_____

_____

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Thank you for completing this form.