ANSON DENTAL STUDIO

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS - *STAY WITHIN THE BOX*

First Name	Middle Initial	Last Name

Weight	Pounds	**Age**	Years	Gender	○ Male ○ Female
Height	Feet / Inches		**Neck Size**	Inches	
Date of Birth	Month / Day / Year		**ID Number**	Optional	

Tally ARES Risk Points

Neck Size
+2 Male ≥ 16.5
+2 Female ≥ 15.0

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

Co-morbidities
+1 for each Yes response

Score

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

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 yo work out how they would have effected 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	○	○	○	○
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 risk)
and 11 or more (very high risk)

Point Total