Sleep Screening Questionnaire

OFFICE USE
Patient ID:_____

NAME: _____ __ _____

CURRENT DATE: ____/____/_____

DATE OF BIRTH: ___/___/_____

MALE

FEMALE

Referring Physician: _____ Contact ID: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

Number #1 = the most severe symptom	Frequency 1-4	Intensity 1-10	Number #1 = the most severe symptom	Frequency 1-4	Intensity 1-10
_ CPAP intolerance			_ Impaired thinking		
_ Difficulty concentrating			_ Insomnia		
_ Excessive daytime sleepiness			_ Morning headaches		
_ Fatigue			_ Nighttime choking spells		
_ Forgetfulness			_ Snoring which affects the sleep of others		
_ Frequent snoring			_ Witnessed cessation of breathing		
_ Gasping causing waking up					

Other: Write In

Clear Form

SLEEP STUDIES

If you have had a Sleep Study, please check one of the following:

◯ Home Sleep Study ◯ Polysomnographic evaluation at a sleep disorder center

Sleep Center Name: _____

Sleep Study Date: ____/____/_____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of _____

The evaluation showed:

	during REM		*Supine*	*Side*
an RDI of	_	_	_	_
an AHI of	_	_	_	_

a nadir SpO_2 of _ T90 _ ODI _ (Oxygen Desaturation Index)

Slow Wave Sleep ◯ Decreased ◯ None

REM Sleep ◯ Decreased ◯ None

CPAP Intolerance

(Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

☐ Refuses CPAP
☐ Noise disturbing sleep and/or bed partner's sleep
☐ Claustrophobic associations
☐ Mask leaks
☐ CPAP restricted movements during sleep
☐ An unconscious need to remove the CPAP
☐ Inability to get the mask to fit properly
☐ CPAP does not seem to be effective
☐ Does not resolve symptoms
☐ Discomfort from headgear
☐ Pressure on the upper lip causing tooth related problems
☐ Noisy
☐ Disturbed or interrupted sleep
☐ Latex allergy
☐ Cumbersome

Other

_____ _____

_____ _____

Other Therapy Attempts

include:

☐ Dieting
☐ BiPAP
☐ Weight loss
☐ Uvulectomy (but continues to have symptoms)
☐ Surgery (Uvuloplasty)
☐ Uvuloplasty (but continues to have symptoms)
☐ Surgery (Uvulectomy)
☐ Positional therapy (side sleeping)
☐ Pillar procedure
☐ Nasal strips
☐ Smoking cessation
☐ CPAP

Clear Form

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing	
○	○	○	○	Sitting and reading
○	○	○	○	Watching TV
○	○	○	○	Sitting inactive in public place (e.g. a theater 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

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: _____ Date: _____

I certify that the medical history information is complete and accurate.

Patient Signature: _____ Date: _____

Clear Form