



SLEEP SCREENING QUESTIONNAIRE

This questionnaire was designed to provide important facts regarding the history of your sleep condition. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible. Please sign each page.

▶ Patient Information

Today's Date _____

Last Name _____ First Name _____ M.I. _____

Age _____ Birth Date _____ Mr. Ms. Miss Mrs. Dr. Male Female

Address _____ City _____ State _____ Zip _____

How long at current address? _____ (If less than three years, please give previous address)

Previous Address _____ City _____ State _____ Zip _____

S.S.N. _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email _____ Responsible Party _____

Family Physician _____

Address _____ City _____ State _____ Zip _____

Family Dentist _____

Address _____ City _____ State _____ Zip _____

Please list other health care practitioners seen in the last 9 months _____

INSURANCE

Member Number _____

Group Number _____

Plan Number _____

Name of Primary
Care Physician _____

Height _____ feet _____ inches

Weight _____ pounds

Referred by _____

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

Please number the complaints with #1 being the most important.

- | | |
|---|---|
| <input type="checkbox"/> Frequent heavy snoring | <input type="checkbox"/> Morning hoarseness |
| <input type="checkbox"/> _____ Which affects the sleep of others | <input type="checkbox"/> Morning headaches |
| <input type="checkbox"/> Significant daytime drowsiness | <input type="checkbox"/> Swelling in ankles or feet |
| <input type="checkbox"/> I have been told that "I stop breathing" when sleeping | <input type="checkbox"/> Nocturnal teeth grinding |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Gasping when waking up | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Nighttime choking spells | <input type="checkbox"/> Jaw clicking |
| <input type="checkbox"/> Feeling unrefreshed in the morning | |

Other: _____

Patient Signature _____ Date _____



► **Sleep Center Evaluation**

Have you ever had an evaluation at a Sleep Center? Yes No

If Yes:

Sleep Center Name and Location _____

Sleep Study Date _____

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The evaluation confirmed a diagnosis of _____ mild
moderate obstructive sleep apnea

The evaluation showed an RDI of _____ and an AHI of _____
severe

► **CPAP Intolerance**

(Continuous Positive Airway Pressure device)

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

I could not tolerate the CPAP device due to

mask leaks

I was unable to get the mask to fit properly

discomfort caused by the straps and headgear

disturbed or interrupted sleep caused by the presence of the device

noise from the device disturbing my sleep and/or bed partner's sleep

CPAP restricted movements during sleep

CPAP does not seem to be effective

pressure on the upper lip causing tooth related problems

a latex allergy

claustrophobic associations

an unconscious need to remove the CPAP apparatus at night

Other _____

► **Other Therapy Attempts**

What other therapies have you had for breathing disorders?

(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

Patient Signature _____ Date _____



► **List any medications which have caused an allergic reaction**

Yes	No	Yes	No	Yes	No	
	Antibiotics		Latex		Plastic	Other allergens
	Aspirin		Local anesthetics		Sedatives	_____
	Barbiturates		Metals		Sleeping pills	_____
	Codeine		Penicillin		Sulfa drugs	_____
	Iodine					

► **List any medications you are currently taking**

Yes	No	Yes	No	Yes	No
	Antacids				
	Antibiotics		Codeine		Pain medication
	Anticoagulants		Cortisone		Sleeping pills
	Antidepressants		Diet pills		Sulfa drugs
	Anti-inflammatory drugs (non-steroid)		Heart medication		Tranquilizers
	Barbiturates		High blood pressure medication		
	Blood thinners		Insulin		Other current medications
			Muscle relaxants		_____
			Nerve pills		_____

► **Medical History**

Yes	No	Yes	No	Yes	No
	Anemia		Heart murmur		Muscle spasms or cramps
	Arteriosclerosis		Heart pounding or beating irregularly during the night		Needing extra pillows to help breathing at night
	Asthma		Heart pacemaker		Nighttime sweating
	Autoimmune disorders		Heart valve replacement		Osteoarthritis
	Bleeding easily		Heartburn or a sour taste in the mouth at night		Osteoporosis
	Chronic sinus problems		Hepatitis		Poor circulation
	Chronic fatigue		High blood pressure		Prior orthodontic treatment
	Congestive heart failure		Immune system disorder		Recent excessive weight gain
	Current pregnancy		Injury to		Rheumatic fever
	Diabetes		Face	Neck	Head
	Difficulty concentrating		Mouth	Teeth	
	Dizziness		Insomnia		Shortness of breath
	Emphysema		Irregular heart beat		Swollen, stiff or painful joints
	Epilepsy		Jaw joint surgery		Thyroid problems
	Fibromyalgia		Low blood pressure		Tonsillectomy (have had)
	Frequent sore throats		Memory loss		Wisdom teeth extraction
	Gastroesophageal Reflux Disease (GERD)		Migraines		Other medical history
	Hay fever		Morning dry mouth		_____
	Heart disorder				_____



▶ **Family History**

1. Have any members of your family (blood kin) had: Yes No
- Heart disease
High blood pressure
Diabetes
2. Have any immediate family members been diagnosed or treated for a sleep disorder?

▶ **Social History**

- Alcohol Consumption: How often do you consume alcohol within 2-3 hours of bedtime?
- Never Once a week Several days a week Daily Occasionally
- Sedative Consumption: How often do you take sedatives within 2-3 hours of bedtime?
- Never Once a week Several days a week Daily Occasionally
- Caffeine Consumption: How often do you consume caffeine within 2-3 hours of bedtime?
- Never Once a week Several days a week Daily Occasionally
- Do you smoke? Yes No If yes, enter the number of packs per day (or other description of quantity): _____

I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature _____ Date _____



► **The Epworth Sleepiness Scale**

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

Check one in each row:

0	1	2	3
No chance of dozing off	Slight chance of dozing	Moderate chance of dozing	High chance of dozing

Sitting and reading

Watching TV

Sitting inactive in a 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

Total Score: _____ (Add columns 0-3)

Patient Signature _____ Date _____



► Berlin Questionnaire Sleep Evaluation

Category 1

1. Complete the following:
Height _____ Age _____
Weight _____ Male/Female _____

2. Do you snore?
Yes
No
Don't know

If you snore:

3. Your snoring is?
Slightly louder than breathing
As loud as talking

Louder than talking
Very loud. Can be heard in adjacent rooms

4. How often do you snore?

Nearly every day
3-4 times a week
1-2 times a week
1-2 times a month
Never or nearly never

5. Has your snoring ever bothered other people?

Yes
No

6. Has anyone noticed that you quit breathing during your sleep?

Nearly every day
3-4 times a week
1-2 times a week
1-2 times a month
Never or nearly never

Category 2

7. How often do you feel tired or fatigued after your sleep?

Nearly every day
3-4 times a week
1-2 times a week
1-2 times a month
Never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?

Nearly every day
3-4 times a week
1-2 times a week
1-2 times a month
Never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?
Yes
No

If yes, how often does it occur?

Nearly every day
3-4 times a week
1-2 times a week
1-2 times a month
Never or nearly never

Category 3

10. Do you have high blood pressure?

Yes
No
Don't know

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Scoring Questions: Any answers within the box outline is a positive response

Scoring categories:

Category 1 is positive with 2 or more positive responses to questions 2-6

Category 2 is positive with 2 or more positive responses to questions 7-9

Category 3 is positive with 1 positive response and/or a BMI > 30

(BMI = Body Mass Index)

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

Patient Signature _____ Date _____

Bed Partner/Witness Screening Questionnaire: Obstructive Sleep Apnea

Name: _____

Person completing form: _____ Date: ___/___/___

Please answer the following questions as they pertain to your bed partner in the past month.

1. While sleeping, does your partner:

Snore more than half the time?.....Y N DK
Always snore?.....Y N DK
Snore loudly?.....Y N DK
Have "heavy" or loud breathing?.....Y N DK
Have trouble breathing, or struggle to breathe?.....Y N DK

2. Have you ever seen your partner stop breathing during the night?.....Y N DK

3. Does your bed partner ever have snorting or choking episodes during the night?.....Y N DK

4. Does your partner:

Tend to breathe through the mouth?.....Y N DK
Have a dry mouth on waking up in the morning?.....Y N DK
Occasionally wet the bed?.....Y N DK

5. Have you ever experienced your partner:

Grinding their teeth during the night?.....Y N DK
Have twitching or kicking of their legs or arms?.....Y N DK

6. Does your partner:

Wake up feeling unrefreshed in the morning?.....Y N DK
Have a problem with sleepiness during the day?.....Y N DK

7. Has a friend, coworker or supervisor commented that your partner appears sleepy during the day?.....Y N DK

8. Is it hard to wake your partner up in the morning?.....Y N DK

9. Does your partner wake up with headaches in the morning?.....Y N DK

10. Is your partner overweight?.....Y N DK