JOSEPH G. MIRCI
D.D.S., M.A.G.D.

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.

_____ Frequent heavy snoring
_____ Which affects the sleep of others
_____ Significant daytime drowsiness
_____ I have been told that "I stop breathing" when sleeping
_____ Difficulty falling asleep
_____ Gasping when waking up
_____ Nighttime choking spells
_____ Feeling unrefreshed in the morning

_____ Morning hoarseness
_____ Morning headaches
_____ Swelling in ankles or feet
_____ Nocturnal teeth grinding
_____ Jaw pain
_____ Facial pain
_____ Jaw clicking

Other: _____

Patient Signature _____ Date _____

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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 ☐ severe obstructive sleep apnea

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

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.)

_____

_____

_____

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List any medications which have caused an allergic reaction

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

Other allergens
_____
_____
_____

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
			☐	☐	High blood pressure medication	☐	☐	
☐	☐	Barbiturates	☐	☐	Insulin			Other current medications
☐	☐	Blood thinners	☐	☐	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						
☐	☐	Autoimmune disorders	☐	☐	Heart pacemaker	☐	☐	Nighttime sweating
☐	☐	Bleeding easily	☐	☐	Heart valve replacement	☐	☐	Osteoarthritis
☐	☐	Chronic sinus problems	☐	☐	Heartburn or a sour taste in the mouth at night	☐	☐	Osteoporosis
☐	☐	Chronic fatigue				☐	☐	Poor circulation
☐	☐	Congestive heart failure	☐	☐	Hepatitis	☐	☐	Prior orthodontic treatment
☐	☐	Current pregnancy	☐	☐	High blood pressure	☐	☐	Recent excessive weight gain
☐	☐	Diabetes	☐	☐	Immune system disorder	☐	☐	Rheumatic fever
☐	☐	Difficulty concentrating	☐	☐	Injury to	☐	☐	Shortness of breath
☐	☐	Dizziness			☐ Face ☐ Neck ☐ Head	☐	☐	Swollen, stiff or painful joints
☐	☐	Emphysema			☐ Mouth ☐ Teeth	☐	☐	Thyroid problems
☐	☐	Epilepsy	☐	☐	Insomnia	☐	☐	Tonsillectomy (have had)
☐	☐	Fibromyalgia	☐	☐	Irregular heart beat	☐	☐	Wisdom teeth extraction
☐	☐	Frequent sore throats Gastroesophageal Reflux Disease (GERD)	☐	☐	Jaw joint surgery	☐	☐	Other medical history
			☐	☐	Low blood pressure			_____
☐	☐	Hay fever	☐	☐	Memory loss			_____
☐	☐	Heart disorder	☐	☐	Migraines			_____
			☐	☐	Morning dry mouth			

Patient Signature_____ Date_____

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Family History

	Yes	No	
1. Have any members of your family (blood kin) had:	☐	☐	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 _____

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The Epworth Sleepiness Scale

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

Check one in each row:

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

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Berlin Questionnaire Sleep Evaluation

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

Category 1

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

(For office use only)

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 _____

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Bed Partner/Witness Screening Questionnaire: Obstructive Sleep Apnea

Patient Name: _____

Person Completeting 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? _____ Yes ◯ No ◯ DK ◯

Always snore? _____ Yes ◯ No ◯ DK ◯

Snore loudly? _____ Yes ◯ No ◯ DK ◯

Have "heavy" or loud breathing? _____ Yes ◯ No ◯ DK ◯

Have trouble breathing, or struggle to breathe? _____ Yes ◯ No ◯ DK ◯

2. Have you ever seen your partner stop breathing during the night? _____ Yes ◯ No ◯ DK ◯

3. Does your bed partner ever have snorting or coking episodes during the night? _____ Yes ◯ No ◯ DK ◯

4. Does your partner:

Tend to breathe through their mouth? _____ Yes ◯ No ◯ DK ◯

Have dry mouth on waking up in the morning? _____ Yes ◯ No ◯ DK ◯

Occasionally wet the bed? _____ Yes ◯ No ◯ DK ◯

5. Have you ever experienced your partner:

Grinding their teeth during the night? _____ Yes ◯ No ◯ DK ◯

Have twitching or kicking of their legs or arms? _____ Yes ◯ No ◯ DK ◯

6. Does your partner:

Wake up feeling unrefreshed in the morning? _____ Yes ◯ No ◯ DK ◯

Have a problem with sleepiness during the day? _____ Yes ◯ No ◯ DK ◯

7. Has a friend, coworker or supervisor commented that your partner appears sleepy during the day? _____ Yes ◯ No ◯ DK ◯

8. Is it hard to wake your partner up in the morning? _____ Yes ◯ No ◯ DK ◯

9. Does your partner wake up with headaches in the morning? _____ Yes ◯ No ◯ DK ◯

10. Is your partner overweight? _____ Yes ◯ No ◯ DK ◯