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: ____________________

☐ MR. ☐ MS ☐ MISS NAME: ____

☐ MRS. ☐ DR. FIRST MIDDLE INITIAL LAST

AGE: ________________ DATE OF BIRTH: ____________ ☐ Male ☐ Female

ADDRESS: ____

CITY/STATE/ZIP: ____

HOW LONG AT CURRENT ADDRESS? ________ (IF LESS THAN THREE YEARS, PLEASE GIVE PREVIOUS ADDRESS)

PREVIOUS ADDRESS: ____

EMPLOYED BY: ____

ADDRESS: ____

SS#: ____

HOME PHONE: ____________________ BUSINESS PHONE: ____________________

RESPONSIBLE PARTY: ____

FAMILY PHYSICIAN ____

ADDRESS ____

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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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	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	☐	☐	☐	☐

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 evalution 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 in 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
- ☐ of 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 ________________

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List any medications which have caused an allergic reaction:

- Y☐ N☐ Antibiotics
- Y☐ N☐ Aspirin
- Y☐ N☐ Barbiturates
- Y☐ N☐ Codeine
- Y☐ N☐ Iodine
- Y☐ N☐ Latex
- Y☐ N☐ Local anesthetics
- Y☐ N☐ Metals
- Y☐ N☐ Penicillin
- Y☐ N☐ Plastic
- Y☐ N☐ Sedatives
- Y☐ N☐ Sleeping pills
- Y☐ N☐ Sulfa drugs

Other allergens: ______________________

____

____

____

List any medications you are currently taking:

- Y☐ N☐ Antacids
- Y☐ N☐ Antibiotics
- Y☐ N☐ Anticoagulants
- Y☐ N☐ Antidepressants
- Y☐ N☐ Anti-inflammatory drugs (non-steroid)
- Y☐ N☐ Barbiturates
- Y☐ N☐ Blood thinners
- Y☐ N☐ Codeine
- Y☐ N☐ Cortisone
- Y☐ N☐ Diet pills
- Y☐ N☐ Heart medication
- Y☐ N☐ High blood pressure medication
- Y☐ N☐ Insulin
- Y☐ N☐ Muscle relaxants
- Y☐ N☐ Nerve pills
- Y☐ N☐ Pain medication
- Y☐ N☐ Sleeping pills
- Y☐ N☐ Sulfa drugs
- Y☐ N☐ Tranquilizers

Other current medications: ______________________

____

____

Medical History

- Y☐ N☐ Anemia
- Y☐ N☐ Arteriosclerosis
- Y☐ N☐ Asthma
- Y☐ N☐ Autoimmune disorders
- Y☐ N☐ Bleeding easily
- Y☐ N☐ Chronic sinus problems
- Y☐ N☐ Chronic fatigue
- Y☐ N☐ Congestive heart failure
- Y☐ N☐ Current pregnancy
- Y☐ N☐ Diabetes
- Y☐ N☐ Difficulty concentrating
- Y☐ N☐ Dizziness
- Y☐ N☐ Emphysema
- Y☐ N☐ Epilepsy
- Y☐ N☐ Fibromyalgia
- Y☐ N☐ Frequent sore throats
- Y☐ N☐ Gastroesophageal Reflux Disease (GERD)
- Y☐ N☐ Hay fever
- Y☐ N☐ Heart disorder
- Y☐ N☐ Heart murmur
- Y☐ N☐ Heart pounding or beating irregularly during the night
- Y☐ N☐ Heart pacemaker
- Y☐ N☐ Heat valve replacement
- Y☐ N☐ Heartburn or a sour taste in the mouth at night
- Y☐ N☐ Hepatitis
- Y☐ N☐ High blood pressure
- Y☐ N☐ Immune system disorder
- Y☐ N☐ Injury to
  - ☐ Face ☐ Neck
  - ☐ Head ☐ Mouth ☐ Teeth
- Y☐ N☐ Insomnia
- Y☐ N☐ Irregular heart beat
- Y☐ N☐ Jaw joint surgery
- Y☐ N☐ Low blood pressure
- Y☐ N☐ Memory loss
- Y☐ N☐ Migraines
- Y☐ N☐ Morning dry mouth
- Y☐ N☐ Muscle spasms or cramps
- Y☐ N☐ Needing extra pillows to help breathing at night
- Y☐ N☐ Nighttime sweating
- Y☐ N☐ Osteoarthritis
- Y☐ N☐ Osteoporosis
- Y☐ N☐ Poor circulation
- Y☐ N☐ Prior orthodontic treatment
- Y☐ N☐ Recent excessive weight gain
- Y☐ N☐ Rheumatic fever
- Y☐ N☐ Shortness of breath
- Y☐ N☐ Swollen, stiff or painful joints
- Y☐ N☐ Thyroid problems
- Y☐ N☐ Tonsillectomy (have had)
- Y☐ N☐ Wisdom teeth extraction

Other medical history:

____

____

____

____

Patient Signature ______________________ Date ______________________

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Family History

1. Have any members of your family (blood kin) had:

Yes ☐	No ☐	Heart disease
Yes ☐	No ☐	High blood pressure
Yes ☐	No ☐	Diabetes

2. Have any immediate family members been diagnosed or treated for a sleep disorder? Yes ☐ No ☐

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

Sedative consumption: How often do you take sedatives within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

Caffeine consumption: How often do you consume caffeine within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

Tobacco consumption: ☐ Smokeless ☐ Smoker ________ Number of packs per day

Patient Signature ______________________________ Date ____________________

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INFORMED CONSENT FOR THE TREATMENT OF SLEEP DISORDERED BREATHING WITH ORAL APPLIANCES

Snoring and obstructive sleep apnea are both breathing disorders that occur during sleep due to narrowing or total closure of the airway. Snoring is a noise created by the partial closure of the airway and may often be no more problematic than the noise itself, however, consistent, loud, heavy snoring as been linked to medical disorders such as high blood pressure. Obstructive sleep apnea is a serious condition; the airway totally closes many times during the night and can significantly reduce oxygen levels in the body and disrupt sleep. In varying degrees, this can result in excessive daytime sleepiness, irregular heartbeat, high blood pressure, reflux, depression, occasionally heart attack and stroke.

Because any sleep disordered breathing may potentially represent a health risk, all individuals will be tested by an overnight sleep recorder in their home or by a polysomnogram in a sleep laboratory.

Oral appliances may be helpful in the treatment of snoring, upper airway resistance syndrome (UARS), and sleep apnea. Oral appliances are designed to assist breathing by keeping the jaw and tongue forward, thereby opening the airway space in the throat. While documented evidence exists that oral appliances have substantially reduced snoring and sleep apnea for many people, there are no guarantees this therapy will be successful for every individual. Several factors contribute to the snoring/apnea condition including nasal obstruction, narrow airway space in the throat and excess weight. Because each person is different and presents with unique circumstances, oral appliances will not reduce snoring and/or apnea for everyone. Post testing will be done to assure effective treatment.

POSSIBLE COMPLICATIONS: Some people may not be able to tolerate the appliance in their mouths. Also, some individuals will develop temporary adverse side effects such as excessive salivation, sore jaw joints, sore teeth and a slight change in their "bite". However, these usually diminish within an hour after appliance removal in the morning. On a rare occasion, a permanent "bite" change may occur due to jaw joint changes and/or tooth movement. Generally, this can be prevented with the exercise bite tabs or other techniques you will be shown. These complications may or may not be fully reversible once appliance therapy is discontinued. If not, restorative, orthodontic, and/or surgical treatment may be required for which you are responsible. Oral appliances can wear and break. The possibility that these or broken parts from them may be swallowed or aspirated exists. For patients with sleep apnea, the device must be worn nightly. Discontinuation of use is a hazard to your health and can lead to a heart attack, or stroke, and even death. See your prescriber before discontinuing use and for recommendations of alternative therapy such as CPAP and/or surgery.

LENGTH OF TREATMENT: The oral appliance is strictly a mechanical device to maintain an open airway during sleep. It does not cure snoring or sleep apnea. Therefore, over time, the device must be worn nightly for a lifetime to be effective. Over time, simple snoring may develop into sleep apnea. Sleep apnea also may become worse. Therefore, the appliance may not maintain its effectiveness. The oral appliance needs to be checked at least twice a year to ensure proper fit and the mouth examined at that time to assure a healthy condition. If any unusual symptoms occur, you are advised to schedule an office visit to evaluate the situation. Individuals who have been diagnosed as having sleep apnea may notice that after sleeping with an oral appliance they feel more refreshed and alert during the day. This is only subjective evidence of improvement and may be misleading. The only way to accurately measure whether the appliance is keeping the oxygen level sufficiently high to prevent abnormal heart rhythms and other problems is to be retested with a sleep recorder or polysomnogram.

ALTERNATIVE TREATMENTS: Other accepted treatments for sleep-disordered breathing include behavior modification, weight loss, constant positive airway pressure, and surgery. These alternatives have been explained and you have chosen oral appliance therapy to treat your particular problem and are aware that it may not be completely effective for you.

UNUSUAL OCCURRENCES: As with any form of medical or dental treatment, unusual occurrences can and do happen. Broken or loosened teeth, dislodged dental restorations, mouth sores, periodontal problems, root resorption, non-vital teeth, muscle spasms, and ear problems, are all possible occurrences.

Most of these complications and unusual occurrences are infrequent. Additional medical and dental risks that have not been mentioned may occur. Good communication is essential for the best treatment results. Please call or come to the office if you have any questions or problems regarding treatment.

DOCTOR'S OFFICE PHONE:

I consent to the taking of photographs and x-rays before, during and after treatment, and their use in scientific papers and demonstrations.

I certify that I have read, or had read to me, the contents of this form. I realize and accept any risks and limitations involved, and do consent to treatment.

_______ Booklet reviewed _______ CD Reviewed _______ Demonstration Model

_______ Other ____________________________

Date: ____________________

Patient: ____ **Witness:** ____