

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: _____ BIRTH DATE: _____ 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: _____

CELL PHONE _____ EMAIL: _____

SPOUSE NAME _____ SPOUSE BIRTH DATE _____

SPOUSE SS# _____

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 _____

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
 severe

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
- 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:

- Antibiotics
 Aspirin
 Barbiturates
 Codeine
 Iodine
 Latex
 Local anesthetics

- Metals
 Penicillin
 Plastic
 Sedatives
 Sleeping pills
 Sulfa drugs

Other allergens:

List any medications you are currently taking:

- Antacids
 Antibiotics
 Anticoagulants
 Antidepressants
 Anti-inflammatory drugs
 (non-steroid)
 Barbiturates
 Blood thinners

- Codeine
 Cortisone
 Diet pills
 Heart medication
 High blood pressure medication
 Insulin
 Muscle relaxants
 Nerve pills

- Pain medication
 Sleeping pills
 Sulfa drugs
 Tranquilizers

Other current medications: _____

Medical History

- Anemia
 Arteriosclerosis
 Asthma
 Autoimmune disorders
 Bleeding easily
 Chronic sinus problems
 Chronic fatigue
 Congestive heart failure
 Current pregnancy
 Diabetes
 Difficulty concentrating
 Dizziness
 Emphysema
 Epilepsy
 Fibromyalgia
 Frequent sore throats
 Gastroesophageal Reflux
 Disease (GERD)
 Hay fever
 Heart disorder
 Heart murmur
 Heart pounding or beating
 irregularly during the night

- Heart pacemaker
 Heart valve replacement
 Heartburn or a sour taste
 in the mouth at night
 Hepatitis
 High blood pressure
 Immune system disorder
 Injury to
 Face Neck
 Head Mouth Teeth
 Insomnia
 Irregular heart beat
 Jaw joint surgery
 Low blood pressure
 Memory loss
 Migraines
 Morning dry mouth
 Muscle spasms or
 cramps
 Needing extra pillows to
 help breathing at night
 Nighttime sweating

- Osteoarthritis
 Osteoporosis
 Poor circulation
 Prior orthodontic treatment
 Recent excessive weight
 gain
 Rheumatic fever
 Shortness of breath
 Swollen, stiff or painful
 joints
 Thyroid problems
 Tonsillectomy (have had)
 Wisdom teeth extraction

Other medical history:

Patient Signature _____

Date _____

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 Yes No
 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

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

Do you smoke? Yes No If yes, enter the number of packs per day (or other description of quantity):

Do you use chewing tobacco? Yes No

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 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature _____

Date _____

Berlin Questionnaire Sleep Evaluation

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

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

10. Do you have high blood pressure?

yes

no

don't know

(For office use)

Scoring Questions: Any answer 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 _____

Berlin