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ADVANCED DENTISTRY

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SLEEP SCREENING QUESTIONNAIRE

Patient Information

Name: _____ DOB: _____ Age: _____

Address: _____ Employer: _____

_____ SS# _____

Home Phone: _____ Work Phone:_____

Cell Phone: _____ EMAIL: _____

Referred By :_____

Height: _____Feet _____ Inches Weight: _____ Pounds

What are the chief complaints for which you are seeking treatment?

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

____Frequent heavy snoring

____Snoring which affects 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 un-refreshed 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 had an evaluation at a sleep center? Yes No

If yes: Center name: _____

Location: _____ Study date: _____

For Office Use Only
The evaluation confirmed a diagnosis of: Mild Moderate Severe OSA
The evaluation showed a RDI of _____ and an AHI of _____

CPAP Intolerance (Continued Positive Airway Pressure device)

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

I could not tolerate CPAP device due to:

__Mask leaks
__Discomfort caused by straps and headgear
__CPAP restricted movement during sleep
__CPAP does not seem to be effective
__A latex allergy
__An unconscious need to remove CPAP apparatus
__I was unable to get mask to fit properly
__Disturbed sleep caused by the presence of device
__Noise from the device disturbing sleep
__Lip Pressure causing tooth related problems
__Claustrophobic associations

Other Therapy Attempts
What other therapy attempts have you had for breathing disorders?
(weight loss attempts, smoking cessation for at least one month, surgeries, etc.)

_____

_____

_____

Patient signature: _____

THE EPWORTH SLEEPINESS SCALE

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 theatre or meting)				
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 alunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Total Score: _____

(Add columns 0-3)

Berlin Questionnaire Sleep Evaluation

Patient name: _____ Date: _____

Complete the following:
Height _____ Weight _____ Age _____ Circle: Male Female

Category 1
Do you snore?
- o Yes
- o No
- o Don't Know

If you snore, your snoring is?
- o Slightly louder than breathing
- o As loud as talking
- o Louder than talking
- o Very loud. Can be heard from other rooms

How often do you snore
- o Nearly every day
- o 3-4 times a week
- o 1-2 times a week
- o 1-2 times a month
- o Never or nearly never

Has your snoring ever bothered other people?
- o Yes
- o No

Has anyone noticed that you quit breathing during your sleep?
- o Nearly every night
- o 3-4 times a week
- o 1-2 times a week
- o 1-2 times a month
- o Never or nearly never

Category 2
How often do you feel tired or fatigued after your sleep?
- o nearly every day
- o 3-4 times a week
- o 1-2 times a week
- o 1-2 times a month
- o never or nearly never

During your waketime, do you feel tired, fatigued or not up to par?
- o Nearly every day
- o 3-4 times a week
- o Don't know
- o 1-2 times a month
- o Never or nearly never

Have you ever nodded off or fallen asleep While driving a vehicle?
- o Yes
- o No

If yes, how often does it occur?
nearly every day
- o 3-4 times a week
- o 1-2 times a week
- o 1-2 times a month
- o never or nearly never

Category 3
Do you have high blood pressure?
- o Yes
- o No
- o 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 ☐
Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

Medical History

List any medications which have caused an allergic reaction:

Please circle:

Antibiotics	Asprin	Barbiturates
Codeine	Iodine	Latex
Local Anesthetics	Metals	Penicillin
Sedatives	Sleeping Pills	Sulfa Drugs
Other _____	Other _____	Other _____

List and Medications you are currently taking:

Please circle:

Antacids	Antibiotics	Anticoagulants
Antidepressants	Anti-inflammatory Drugs	Barbiturates
Blood thinners	Codeine	Cortisone
Diet Pills	Heart Medication	High Blood Pressure
Insulin	Muscle relaxants	Nerve Pills
Pain Medication	Sleeping Pills	Sulfa Drugs
Tranquilizers	Other _____	Other _____

Medical History:

Please circle:

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 throat	GERD	Hay fever
Heart disorder	Heart murmur	Heart pounding or irregular beating
Heart pacemaker	Heart valve replacement	Heartburn
Hepatitis	High Blood Pressure	Immune system disorder
Head, face injury	Insomnia	Irregular heartbeat
Jaw joint surgery	Low blood pressure	Memory loss
Migraines	Morning dry mouth	Muscle spasms or cramps
Nighttime sweating	Osteoarthritis	Osteoporosis
Poor circulation	Prior orthodontic treatment	Recent, excessive weight gain
Rheumatic fever	Shortness of breath	Swollen, stiff, painful joints
Thyroid problems	Tonsillectomy	Wisdom teeth removed
Other: _____	Other: _____	Other: _____

Patient signature: _____ Date: _____

Family History

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

Heart disease	Yes	No
High Blood Pressure	Yes	No
Diabetes	Yes	No

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 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 Number of packs per day: _____

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: _____