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Sleep Screening Information

DATE: _______________

NAME: ____
FIRST MIDDLE INITIAL LAST

AGE: ____ BIRTHDATE: ____________ MALE: ___FEMALE: __ MARRIED: YES___ NO___

ADDRESS: ____

CITY/STATE/ZIP: ____

HOME PHONE: ________________________ WORK PHONE: _______________________

CELL PHONE: _________________________ E-MAIL: ___________________________

OCCUPATION: _________________________ EMPLOYER: ______________________

HEIGHT: ___________ WEIGHT: __________

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
____ Have been told that "I stop breathing"
____ 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: ____

Client Signature: ____

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	☐	☐	☐	☐

Total Score: ____________

(Add columns 0-3)

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
- ☐ 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☐ Heart 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 ☐ 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): ______________________________

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 ____________________

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