



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: _____

Patient Name: _____

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: _____

Employer: _____

Employer Address: _____

SSN: _____ Email: _____

Phone: (H) _____ (W) _____ (C) _____

Physician (GP) Name: _____

Physician's Address: _____ Phone: _____

Family Dentist Name: _____

Family Dentist's Address: _____ Phone: _____

Please list other health care practitioners seen in the last nine months: _____

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured SSN: _____ Insured Birth Date: _____

Employer: _____

Address: _____

City, State, Zip: _____

Insurance Company: _____

Address: _____

City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Referred by: _____

Patient/Guardian Signature

Date



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

Please number the complaints with #1 being the MOST important.

- | | |
|--|----------------------------------|
| _____ Frequent heavy snoring | _____ Morning hoarseness |
| _____ _____ which affects the sleep of others | _____ Morning headaches |
| _____ Significant daytime drowsiness | _____ Swelling in ankles or feet |
| _____ I have been told that I stop breathing when sleeping | _____ Nocturnal teeth grinding |
| _____ Difficulty falling asleep | _____ Jaw pain |
| _____ Gasping when waking up | _____ Facial pain |
| _____ Nighttime choking spells | _____ Jaw clicking |
| _____ Feeling unfreshed in the morning | _____ Other: _____ |
| _____ Other: _____ | |

Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center? Yes No

If yes: Sleep Study Date: _____

Sleep Center Name/Location: _____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of: mild moderate severe obstructive sleep apnea
The evaluation showed an RDI of _____ and an AHI of _____

Height: _____ Weight: _____

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:

- | | |
|---|--|
| <input type="radio"/> Mask Leaks | <input type="radio"/> CPAP does not seem to be effective |
| <input type="radio"/> I was unable to get the mask to fit properly | <input type="radio"/> Pressure on the upper lip causing tooth-related problems |
| <input type="radio"/> Discomfort caused by straps and headgear | <input type="radio"/> Allergy to latex |
| <input type="radio"/> Disturbed or interrupted sleep caused by presence of the device | <input type="radio"/> Claustrophobic associations |
| <input type="radio"/> Noise from device disturbed my sleep and/or bed partner's sleep | <input type="radio"/> An unconscious need to remove CPAP apparatus at night |
| <input type="radio"/> CPAP restricted movements during sleep | <input type="radio"/> 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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Please list any medications which have caused an allergic reaction:

Antibiotics	<input type="radio"/> Yes <input type="radio"/> No	Metals	<input type="radio"/> Yes <input type="radio"/> No	Other allergens: _____ _____ _____ _____
Aspirin	<input type="radio"/> Yes <input type="radio"/> No	Penicillin	<input type="radio"/> Yes <input type="radio"/> No	
Barbiturates	<input type="radio"/> Yes <input type="radio"/> No	Plastic	<input type="radio"/> Yes <input type="radio"/> No	
Codeine	<input type="radio"/> Yes <input type="radio"/> No	Sedatives	<input type="radio"/> Yes <input type="radio"/> No	
Iodine	<input type="radio"/> Yes <input type="radio"/> No	Sleeping Pills	<input type="radio"/> Yes <input type="radio"/> No	
Latex	<input type="radio"/> Yes <input type="radio"/> No	Sulfa Drugs	<input type="radio"/> Yes <input type="radio"/> No	
Local Anesthetics	<input type="radio"/> Yes <input type="radio"/> No			

Please list any medications you are currently taking:

Antacids	<input type="radio"/> Yes <input type="radio"/> No	Cortisone	<input type="radio"/> Yes <input type="radio"/> No	Sleeping Pills	<input type="radio"/> Yes <input type="radio"/> No
Antibiotics	<input type="radio"/> Yes <input type="radio"/> No	Diet Pills	<input type="radio"/> Yes <input type="radio"/> No	Sulfa Drugs	<input type="radio"/> Yes <input type="radio"/> No
Anticoagulants	<input type="radio"/> Yes <input type="radio"/> No	Heart Medication	<input type="radio"/> Yes <input type="radio"/> No	Tranquilizers	<input type="radio"/> Yes <input type="radio"/> No
Antidepressants	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure Medication	<input type="radio"/> Yes <input type="radio"/> No	Other current medications:	_____
Anti-Inflammatory Drugs (non-steroid)	<input type="radio"/> Yes <input type="radio"/> No	Insulin	<input type="radio"/> Yes <input type="radio"/> No	_____	
Barbiturates	<input type="radio"/> Yes <input type="radio"/> No	Muscle Relaxants	<input type="radio"/> Yes <input type="radio"/> No	_____	
Blood Thinners	<input type="radio"/> Yes <input type="radio"/> No	Nerve Pills	<input type="radio"/> Yes <input type="radio"/> No	_____	
Codeine	<input type="radio"/> Yes <input type="radio"/> No	Pain Medication	<input type="radio"/> Yes <input type="radio"/> No	_____	

Medical History:

Anemia	<input type="radio"/> Yes <input type="radio"/> No	Heart Pounding or Beating Irregularly During the Night	<input type="radio"/> Yes <input type="radio"/> No	Morning Dry Mouth	<input type="radio"/> Yes <input type="radio"/> No
Arteriosclerosis	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Muscle Spasms or Cramps	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Heart Valve Replacement	<input type="radio"/> Yes <input type="radio"/> No	Needing Extra Pillows to Help Breathing at Night	<input type="radio"/> Yes <input type="radio"/> No
Autoimmune Disorders	<input type="radio"/> Yes <input type="radio"/> No	Heartburn or Sour Taste in Mouth at Night	<input type="radio"/> Yes <input type="radio"/> No	Nighttime Sweating	<input type="radio"/> Yes <input type="radio"/> No
Bleeding Easily	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	Osteoarthritis	<input type="radio"/> Yes <input type="radio"/> No
Chronic Sinus Problems	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Chronic Fatigue	<input type="radio"/> Yes <input type="radio"/> No	Immune System Disorder	<input type="radio"/> Yes <input type="radio"/> No	Poor Circulation	<input type="radio"/> Yes <input type="radio"/> No
Congestive Heart Failure (CHF)	<input type="radio"/> Yes <input type="radio"/> No	Injury to:		Prior Orthodontic Treatment	<input type="radio"/> Yes <input type="radio"/> No
Current Pregnancy	<input type="radio"/> Yes <input type="radio"/> No	Face	<input type="radio"/> Yes <input type="radio"/> No	Recent Excessive Weight Gain	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Neck	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Difficulty Concentrating	<input type="radio"/> Yes <input type="radio"/> No	Head	<input type="radio"/> Yes <input type="radio"/> No	Shortness of Breath	<input type="radio"/> Yes <input type="radio"/> No
Dizziness/Faintness	<input type="radio"/> Yes <input type="radio"/> No	Mouth	<input type="radio"/> Yes <input type="radio"/> No	Swollen, Stiff or Painful Joints	<input type="radio"/> Yes <input type="radio"/> No
Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Teeth	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Problems	<input type="radio"/> Yes <input type="radio"/> No
Epilepsy	<input type="radio"/> Yes <input type="radio"/> No	Insomnia	<input type="radio"/> Yes <input type="radio"/> No	Tonsillectomy (have had)	<input type="radio"/> Yes <input type="radio"/> No
Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Wisdom Teeth Extraction	<input type="radio"/> Yes <input type="radio"/> No
Frequent Sore Throats	<input type="radio"/> Yes <input type="radio"/> No	Jaw Joint Surgery	<input type="radio"/> Yes <input type="radio"/> No	Other current medications:	_____
Gastroesophageal Reflux Disease (GERD)	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	_____	
Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Memory Loss	<input type="radio"/> Yes <input type="radio"/> No	_____	
Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Migraines	<input type="radio"/> Yes <input type="radio"/> No	_____	
Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No				

COMMENTS: _____

Patient/Guardian Signature

Date



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Family History:

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

- Heart Disease Yes No
- High Blood Pressure Yes No
- Diabetes Yes No

2. Have any members of your family (blood kin) 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 per week
- Daily
- Occasionally

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

- Never
- Once a week
- Several days per week
- Daily
- Occasionally

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

- Never
- Once a week
- Several days per week
- Daily
- Occasionally

Do you smoke?

- Yes
- No

If yes, please enter the number of packs per day (or other description of quantity): _____

Do you use chewing tobacco?

- Yes
- No

COMMENTS: _____

AUTHORIZATION AND RELEASE

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/Guardian Signature

Date