OAK PARK DENTAL

Enhancing your life, health and smile.

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

SLEEP SCREENING QUESTIONNAIRE

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 unfreshed in the morning
________ Other:________________________________

________ Morning hoarseness
________ Morning headaches
________ Swelling in ankles or feet
________ Nocturnal teeth grinding
________ Jaw pain
________ Factial pain
________ Jaw clicking
________ 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:

❍ Mask Leaks
❍ I was unable to get the mask to fit properly
❍ Discomfort caused by straps and headgear
❍ Disturbed or interrupted sleep caused by presence of the device
❍ Noise from device disturbed 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
❍ Allergy to latex
❍ Claustrophobic associations
❍ An unconscious need to remove 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/Guardian Signature

________________ Date

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Please list any medications which have caused an allergic reaction:

Medication	Response
Antibiotics	❍ Yes ❍ No
Aspirin	❍ Yes ❍ No
Barbiturates	❍ Yes ❍ No
Codeine	❍ Yes ❍ No
Iodine	❍ Yes ❍ No
Latex	❍ Yes ❍ No
Local Anesthetics	❍ Yes ❍ No
Metals	❍ Yes ❍ No
Penicillin	❍ Yes ❍ No
Plastic	❍ Yes ❍ No
Sedatives	❍ Yes ❍ No
Sleeping Pills	❍ Yes ❍ No
Sulfa Drugs	❍ Yes ❍ No

Other allergens:

____

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Please list any medications you are currently taking:

Medication	Response
Antacids	❍ Yes ❍ No
Antibiotics	❍ Yes ❍ No
Anticoagulants	❍ Yes ❍ No
Antidepressants	❍ Yes ❍ No
Anti-Inflammatory Drugs (non-steroid)	❍ Yes ❍ No
Barbiturates	❍ Yes ❍ No
Blood Thinners	❍ Yes ❍ No
Codeine	❍ Yes ❍ No
Cortisone	❍ Yes ❍ No
Diet Pills	❍ Yes ❍ No
Heart Medication	❍ Yes ❍ No
High Blood Pressure Medication	❍ Yes ❍ No
Insulin	❍ Yes ❍ No
Muscle Relaxants	❍ Yes ❍ No
Nerve Pills	❍ Yes ❍ No
Pain Medication	❍ Yes ❍ No
Sleeping PIlls	❍ Yes ❍ No
Sulfa Drugs	❍ Yes ❍ No
Tranquilizers	❍ Yes ❍ No

Other current medications:

____

____

____

Medical History:

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

Other current medications:

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COMMENTS: _______________

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_______________ 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: ____

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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