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 ☐ MRS. ☐ DR. NAME: _____ (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: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

RESPONSIBLE PARTY: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____

FAMILY DENTIST: _____

ADDRESS: _____

Please list other health care practitioners seen in the last 9 months: _____

_____

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 <u>number</u> 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 _____

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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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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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Berlin Questionnaire Sleep Evaluation

1. Complete the following:

height _____ age _____

weight _____ male/female _____

category 1

2. Do you snore?

- ☐ yes
- ☐ no
- ☐ don't know

If you snore:

3. Your snoring is?

- ☐ slighly 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

category 2

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

category 3

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 _____

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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