Version: SLPQV1

Sleep Screening Questionnaire

OFFICE USE
Patient ID:____

NAME: ___________________ _ ___________________

CURRENT DATE: ____/____/_______ ☐ MALE

DATE OF BIRTH: ___/___/______ ☐ FEMALE

Referring Physician: ____ Contact ID: ____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

2. Then rate your complaints for frequency and intensity:

Frequency
1-SELDOM 2-OCCASIONAL 3-FREQUENT 4-EVERYDAY

Intensity
0=NO PAIN and 10 is MOST SEVERE PAIN

Number #1 = the most severe symptom		Frequency 1-4	Intensity 1-10
☐	CPAP intolerance	☐	☐
☐	Difficulty concentrating	☐	☐
☐	Excessive daytime sleepiness	☐	☐
☐	Fatigue	☐	☐
☐	Forgetfulness	☐	☐
☐	Frequent snoring	☐	☐
☐	Do you have trouble Keeping legs still at night	☐	☐
☐	Impaired thinking	☐	☐
☐	Insomnia	☐	☐
☐	Morning headaches	☐	☐
☐	Ever been told you stopped breathing in sleep	☐	☐
☐	Snoring which affects the sleep of others	☐	☐
☐	Wake up choking or gasping	☐	☐

Number #1 = the most severe symptom | Frequency 1-4 | Intensity 1-10

Please answer Yes (Y) or No (N) if you have ever been diagnosed or treated for any of the following conditions:

High Blood Pressure ___

Heart Disease ___

Diabetes ___

Stroke ___

Depression ___

Sleep Apnea ___

Lung Disease ___

Insomnia ___

Narcolepsy ___

Sleep Medication ___

Nasal Oxygen Use ___

Restless Leg Syndrome ___

Morning Headaches ___

Pain Medication e.g., vicodin, oxycontin ___

For Health purposes, please fill out the following information below:

Weight (lbs) ___________

Height (in.) ___________

Neck Size (in.) __________

Other: Write In

Patient Signature: ____ Date: ____

SLEEP STUDIES

If you have had a Sleep Study, please check one of the following:

☐ Home Sleep Study ☐ Polysomnographic evaluation at a sleep disorder center

Sleep Center Name: ____________________

Sleep Study Date: ____/____/______

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of ____________________

The evaluation showed:

		during REM	Supine	Side
an RDI of				
an AHI of				

a nadir SpO_2 of ____ T90 ____ ODI ____ (Oxygen Desaturation Index)

Slow Wave Sleep ☐ Decreased ☐ None

REM Sleep ☐ Decreased ☐ None

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:

☐ Refuses CPAP

☐ Noise disturbing sleep and/or bed partner's sleep

☐ Claustrophobic associations

☐ Mask leaks

☐ CPAP restricted movements during sleep

☐ An unconscious need to remove the CPAP

☐ Inability to get the mask to fit properly

☐ CPAP does not seem to be effective

☐ Does not resolve symptoms

☐ Discomfort from headgear

☐ Pressure on the upper lip causing tooth related problems

☐ Noisy

☐ Disturbed or interrupted sleep

☐ Latex allergy

☐ Cumbersome

Other

____________________ ____________________

____________________ ____________________

Other Therapy Attempts

include:

☐ Dieting

☐ BiPAP

☐ Weight loss

☐ Uvulectomy (but continues to have symptoms)

☐ Surgery (Uvuloplasty)

☐ Uvuloplasty (but continues to have symptoms)

☐ Surgery (Uvulectomy)

☐ Positional therapy (side sleeping)

☐ Pillar procedure

☐ Nasal strips

☐ Smoking cessation

☐ CPAP

Patient Signature: ____________________ Date: ____________

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No chance of dozing	**Slight** chance of dozing	**Moderate** chance of dozing	**High** chance of dozing	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	Sitting inactive in 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

Fatigue Scale

During the past week:	**No <**						**> Yes**
	1	**2**	**3**	**4**	**5**	**6**	**7**
I felt fatigued and had less motivation	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and did not desire to exercise	☐	☐	☐	☐	☐	☐	☐
I felt fatigued often	☐	☐	☐	☐	☐	☐	☐
I felt fatigue that interfered with my physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which caused me frequent problems	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which prevented sustained physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and couldn't carry out certain duties and responsibilities	☐	☐	☐	☐	☐	☐	☐
Fatigue was among my three most disabling symptoms	☐	☐	☐	☐	☐	☐	☐
Fatigue interfered with my work, family or social life	☐	☐	☐	☐	☐	☐	☐

Total Score: ______

Patient Signature: ______ Date: ______

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: ______ Date: ______

I certify that the medical history information is complete and accurate.

Patient Signature: ______ Date: ______