Version: SLPQV2

Sleep History/Exam/Workup Questionnaire

OFFICE USE
Patient ID:____

NAME: _____ __ _____

CURRENT DATE: ____/____/_____

DATE OF BIRTH: ___/___/_____ ☐ MALE ☐ FEMALE

Referring Physician: Contact ID:

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

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

Number #1 = the most severe symptom		Number #1 = the most severe symptom	
☐	CPAP intolerance	☐	Impaired thinking
☐	Difficulty concentrating	☐	Insomnia
☐	Excessive daytime sleepiness	☐	Morning headaches
☐	Fatigue	☐	Nighttime choking spells
☐	Forgetfulness	☐	Snoring which affects the sleep of others
☐	Frequent snoring	☐	Witnessed cessation of breathing
☐	Gasping causing waking up		

Other: Write In

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

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 quietly after a lunch without alcohol
☐	☐	☐	☐	In a car, while stopped for a few minutes in traffic

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

Additional Questions

☐ Yes ☐ No Are you a current CPAP (Continuous Positive Air Pressure) user?

If Yes, what are the current CPAP settings: _____

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

Patient Signature: _____ Date: _____

CPAP Intolerance

(Continuous Positive Airway Pressure device)

Other

Other Therapy Attempts

include:

- ☐ Dieting
- ☐ Weight loss
- ☐ Surgery (Uvuloplasty)
- ☐ Surgery (Uvulectomy)
- ☐ Pillar procedure
- ☐ Smoking cessation
- ☐ CPAP
- ☐ BiPAP
- ☐ Uvulectomy (but continues to have symptoms)
- ☐ Uvuloplasty (but continues to have symptoms)
- ☐ Positional therapy (side sleeping)
- ☐ Nasal strips

History Of Treatment

Practitioner's Name	Specialty	Treatment	Approximate Date

Sleep History

Previous Diagnosis

Have you been previously diagnosed with Obstructive Sleep Apnea? ☐ Yes ☐ No

If yes, how long ago was it? ☐ *number* ☐ Years ago ☐ Months ago ☐ Days ago

Sleep:

Sleep Onset Latency ☐ minutes

Normally goes to bed at ☐ ☐ AM PM

Hours of sleep per night ☐ hours

☐ Gasping

☐ Getting up <# of times> per night

Sleep Aid ☐ Yes ☐ No

If yes, name the medication:

- ☐ Bruxism (grinding teeth)
- ☐ Dry mouth
- ☐ Excessive movements

Patient Signature: Date:

Sleep History

Witnessed apneas are:

- ☐ Worse when sleeping on your back
- ☐ Worse following alcohol late at night

Wake

Sleepiness while driving ☐ Yes ☐ No

Risks Discussed ☐ Yes ☐ No

The patient:

- ☐ Awakens unrefreshed
- ☐ Has morning headaches

Naps
- ☐ naps daily
- ☐ never naps
- ☐ occasionally naps
- ☐ _____

Snoring is reported as:

Frequency
- ☐ seldom
- ☐ never
- ☐ daily
- ☐ often
- ☐ _____

- ☐ Worse when sleeping on your back
- ☐ Worse following alcohol late at night

Severity
- ☐ light
- ☐ moderate
- ☐ loud
- ☐ _____

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: _____