

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?

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

Number

#1 = the most severe symptom

CPAP intolerance

Difficulty concentrating

Excessive daytime sleepiness

Fatigue

Forgetfulness

Frequent snoring

Gasping causing waking up

Number

#1 = the most severe symptom

Impaired thinking

Insomnia

Morning headaches

Nighttime choking spells

Snoring which affects the sleep of others

Witnessed cessation of breathing

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:

	<i>during REM</i>			
	<i>Supine</i>	<i>Side</i>	<i>Side</i>	<i>Side</i>
an RDI of	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>
an AHI of	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>

a nadir SpO₂ 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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Refuses CPAP | <input type="checkbox"/> Noise disturbing sleep and/or bed partner's sleep | <input type="checkbox"/> Claustrophobic associations |
| <input type="checkbox"/> Mask leaks | <input type="checkbox"/> CPAP restricted movements during sleep | <input type="checkbox"/> An unconscious need to remove the CPAP |
| <input type="checkbox"/> Inability to get the mask to fit properly | <input type="checkbox"/> CPAP does not seem to be effective | <input type="checkbox"/> Does not resolve symptoms |
| <input type="checkbox"/> Discomfort from headgear | <input type="checkbox"/> Pressure on the upper lip causing tooth related problems | <input type="checkbox"/> Noisy |
| <input type="checkbox"/> Disturbed or interrupted sleep | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Cumbersome |

Other

Other Therapy Attempts

include:

- | | |
|--|---|
| <input type="checkbox"/> Dieting | <input type="checkbox"/> BiPAP |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Uvullectomy (but continues to have symptoms) |
| <input type="checkbox"/> Surgery (Uvuloplasty) | <input type="checkbox"/> Uvuloplasty (but continues to have symptoms) |
| <input type="checkbox"/> Surgery (Uvullectomy) | <input type="checkbox"/> Positional therapy (side sleeping) |
| <input type="checkbox"/> Pillar procedure | <input type="checkbox"/> Nasal strips |
| <input type="checkbox"/> Smoking cessation | |
| <input type="checkbox"/> CPAP | |

Patient Signature:

Date:

Other Therapy Attempts

include:

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	
1	2	3	4	Sitting and reading
1	2	3	4	Watching TV
1	2	3	4	Sitting inactive in public place (e.g. a theater or a meeting)
1	2	3	4	As a passenger in a car for an hour without a break
1	2	3	4	Lying down to rest in the afternoon when circumstances permit
1	2	3	4	Sitting and talking to someone
1	2	3	4	Sitting quietly after a lunch without alcohol
1	2	3	4	In a car, while stopped for a few minutes in traffic

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: