

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 NAME: _____
 MRS. DR. 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: _____ BUSINESS PHONE: _____

CELL PHONE _____ EMAIL: _____

SPOUSE NAME _____ SPOUSE BIRTH DATE _____

SPOUSE SS# _____

RESPONSIBLE PARTY: _____

FAMILY PHYSICIAN _____

ADDRESS _____

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 number the complaints with #1 being the most important.

- | | |
|--|---------------------------------|
| ____ Frequent heavy snoring | ____ Morning hoarseness |
| ____ which affects the sleep of others | ____ Morning headaches |
| ____ Significant daytime drowsiness | ____ Swelling in ankles or feet |
| ____ I have been told that "I stop breathing" when sleeping. | ____ Nocturnal teeth grinding |
| ____ Difficulty falling asleep | ____ Jaw pain |
| ____ Gasping when waking up | ____ Facial pain |
| ____ Nighttime choking spells | ____ Jaw clicking |
| ____ Feeling unrefreshed in the morning | |

Other: _____

Patient Signature _____ Date _____

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 _____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of: *mild*
 moderate obstructive sleep apnea
 severe

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 _____

List any medications which have caused an allergic reaction:

- Y N Antibiotics
 Y N Aspirin
 Y N Barbiturates
 Y N Codeine
 Y N Iodine
 Y N Latex
 Y N Local anesthetics

- Y N Metals
 Y N Penicillin
 Y N Plastic
 Y N Sedatives
 Y N Sleeping pills
 Y N Sulfa drugs

Other allergens:

List any medications you are currently taking:

- Y N Antacids
 Y N Antibiotics
 Y N Anticoagulants
 Y N Antidepressants
 Y N Anti-inflammatory drugs
 (non-steroid)
 Y N Barbiturates
 Y N Blood thinners

- Y N Codeine
 Y N Cortisone
 Y N Diet pills
 Y N Heart medication
 Y N High blood pressure medication
 Y N Insulin
 Y N Muscle relaxants
 Y N Nerve pills

- Y N Pain medication
 Y N Sleeping pills
 Y N Sulfa drugs
 Y N Tranquilizers

Other current medications:

Medical History

- Y N Anemia
 Y N Arteriosclerosis
 Y N Asthma
 Y N Autoimmune disorders
 Y N Bleeding easily
 Y N Chronic sinus problems
 Y N Chronic fatigue
 Y N Congestive heart failure
 Y N Current pregnancy
 Y N Diabetes
 Y N Difficulty concentrating
 Y N Dizziness
 Y N Emphysema
 Y N Epilepsy
 Y N Fibromyalgia
 Y N Frequent sore throats
 Y N Gastroesophageal Reflux
 Disease (GERD)
 Y N Hay fever
 Y N Heart disorder
 Y N Heart murmur
 Y N Heart pounding or beating
 irregularly during the night

- Y N Heart pacemaker
 Y N Heart valve replacement
 Y N Heartburn or a sour taste
 in the mouth at night
 Y N Hepatitis
 Y N High blood pressure
 Y N Immune system disorder
 Y N Injury to
 Face Neck
 Head Mouth Teeth
 Y N Insomnia
 Y N Irregular heart beat
 Y N Jaw joint surgery
 Y N Low blood pressure
 Y N Memory loss
 Y N Migraines
 Y N Morning dry mouth
 Y N Muscle spasms or
 cramps
 Y N Needing extra pillows to
 help breathing at night
 Y N Nighttime sweating

- Y N Osteoarthritis
 Y N Osteoporosis
 Y N Poor circulation
 Y N Prior orthodontic treatment
 Y N Recent excessive weight
 gain
 Y N Rheumatic fever
 Y N Shortness of breath
 Y N Swollen, stiff or painful
 joints
 Y N Thyroid problems
 Y N Tonsillectomy (have had)
 Y N Wisdom teeth extraction

Other medical history:

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature _____

Date _____

1. Do you snore: Y N Don't know *Cat I*

IF YOU SNORE:

2. Your snoring is:

- Slightly louder than breathing
- As loud as talking
- Louder than talking**
- Very loud**

3. How often do you snore?

- Almost every day**
- 3-4 times a week**
- 1-2 times a week
- Never or almost never

4. Does your snoring bother other people? Y N

5. Has anyone noticed that you quit breathing during your sleep?

- Almost every day**
- 3-4 times a week**
- 1-2 times a week
- Never or almost never

6. Are you tired after sleeping? *Cat II*

- Almost every day**
- 3-4 times a week**
- 1-2 times a month
- Never or almost never

7. Are you tired during waketime?

- Almost every day**
- 3-4 times a week**
- 1-2 times a month
- Never or almost never

8. Have you ever nodded off or fallen asleep while driving? Y N

If yes, how often does it occur?

- Every day**
- 3-4 times a week**
- 1-2 times a week
- 1-2 times a month
- Never or almost never

9. Do you have high blood pressure? *Cat III*

- Yes**
- No
- Don't know

BERLIN QUESTIONNAIRE

Patient Name: _____

Date: _____

Ht. _____ Wt. _____ Age _____

Female Male

Has your weight changed recently? Y N