

# 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 \_\_\_\_\_

<b>INSURANCE</b>
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.

- |  |   |
|--|---|
| <input type="checkbox"/> Frequent heavy snoring                                  | <input type="checkbox"/> Morning hoarseness         |
| <input type="checkbox"/> _____ which affects the sleep of others                 | <input type="checkbox"/> Morning headaches          |
| <input type="checkbox"/> Significant daytime drowsiness                          | <input type="checkbox"/> Swelling in ankles or feet |
| <input type="checkbox"/> I have been told that "I stop breathing" when sleeping. | <input type="checkbox"/> Nocturnal teeth grinding   |
| <input type="checkbox"/> Difficulty falling asleep                               | <input type="checkbox"/> Jaw pain                   |
| <input type="checkbox"/> Gasping when waking up                                  | <input type="checkbox"/> Facial pain                |
| <input type="checkbox"/> Nighttime choking spells                                | <input type="checkbox"/> Jaw clicking               |
| <input type="checkbox"/> 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.)

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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:

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## 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:

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## 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:

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Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

