

Sleep Consultation

OFFICE USE
Patient ID: _____

NAME: _____ TODAY'S DATE _____
First Middle Initial Last

DATE OF BIRTH: _____ MALE FEMALE

Number

#1 = the most severe symptom

- _____ TMD / PAIN COMPLAINTS
- _____ Difficulty Swallowing
- _____ Dizziness
- _____ Facial Pain
- _____ Headaches
- _____ Jaw Clicking
- _____ Jaw Locking
- _____ Jaw Pain
- _____ Limited Mouth Opening
- _____ Migraines
- _____ Morning Head Pain
- _____ Morning Hoarseness
- _____ Neck Pain
- _____ Nocturnal Teeth Grinding
- _____ Pain when Chewing

Number

#1 = the most severe symptom

- _____ Ringing in the Ears
- _____ SLEEP BREATHING COMPLAINTS
- _____ CPAP Intolerance
- _____ Difficulty Falling Asleep
- _____ Fatigue
- _____ Frequent Heavy Snoring
- _____ Frequent Heavy Snoring Which Affects the Sleep of Others
- _____ Gasping when Waking Up
- _____ Nighttime Choking Spells
- _____ I have been told that "I stop breathing" when sleeping.
- _____ Significant Daytime Drowsiness
- _____ Sleepy while Driving
- _____ Witnessed Apneic Events
- _____ Feeling unrefreshed in the morning
- _____ Swelling in ankles or feet

SLEEP STUDIES

Have you ever had an evaluation at a Sleep Center? Yes No

Sleep Center Name _____
and Location _____

Sleep Study Date _____

FOR OFFICE USE ONLY		<input type="checkbox"/> mild
The evaluation confirmed a diagnosis of	<input type="checkbox"/> moderate	obstructive sleep apnea
	<input type="checkbox"/> severe	
The evaluation showed		
an RDI of _____ during REM _____ Supine _____ Side _____		
an AHI of _____ during REM _____ Supine _____ Side _____		
a nadir SpO2 of _____ T90 _____		
Slow Wave Sleep	<input type="checkbox"/> Decreased	<input type="checkbox"/> None
REM Sleep	<input type="checkbox"/> Decreased	<input type="checkbox"/> None

Patient Signature _____ Date _____

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"/> Yes <input type="checkbox"/> No | Mask leaks | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pressure on the upper lip causing tooth related problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Inability to get the mask to fit properly | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex allergy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Discomfort from headgear | <input type="checkbox"/> Yes <input type="checkbox"/> No | Claustrophobic associations |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Disturbed or interrupted sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No | An unconscious need to remove the CPAP |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Noise disturbing sleep and/or bed partner's sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No | Does not resolve symptoms |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | CPAP restricted movements during sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No | Noisy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | CPAP does not seem to be effective | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cumbersome |

Other _____

OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders?

- | | | | |
|--|-----------------------|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Dieting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Smoking cessation |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | CPAP |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Surgery (Uvuloplasty) | <input type="checkbox"/> Yes <input type="checkbox"/> No | BiPap |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Surgery (Uvulectomy) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Uvulectomy (but continues to have symptoms) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Pillar procedure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Uvuloplasty (but continues to have symptoms) |

Other _____

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 (i.e. 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 stopping for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score: _____ (Add columns 0-3)

Patient Signature _____

Date _____

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FATIGUE SCALE

During the past week:

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

Total Score: _____

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature _____ Date _____

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

Patient Signature _____ Date _____