Smiles for Life Dental Group

Version: SLPQV2

Sleep Consultation

OFFICE USE
Patient ID: _____

NAME: _____ CURRENT DATE: __/__/____
First *Middle Initial* *Last*

DATE OF BIRTH: _____ ☐MALE ☐FEMALE

Referring Physician: _____

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

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

2. Then rate your complaints for frequency and intensity:

Frequency
1-SELDOM 2-OCCASIONAL 3-FREQUENT 4-EVERYDAY

Intensity
0=NO PAIN and 10 is MOST SEVERE PAIN

Number *#1 = the most severe symptom*		**Frequency** **1-4**	**Intensity** **1-10**
____	CPAP intolerance	____	____
____	Difficulty falling asleep	____	____
____	Fatigue	____	____
____	Frequent heavy snoring	____	____
____	Frequent heavy snoring which affects the sleep of others	____	____
	Other - Write in:		
____	_____	____	____
____	_____	____	____
____	_____	____	____

Continued...		**Frequency** **1-4**	**Intensity** **1-10**
____	Gasping when waking up	____	____
____	Nighttime choking spells	____	____
____	Significant daytime drowsiness	____	____
____	Sleepiness while driving	____	____
____	Witnessed apneic events	____	____
____	_____	____	____
____	_____	____	____
____	_____	____	____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situatons?

✓ **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	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (i.e. 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	☐	☐	☐	☐
Sitting quitely after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopping for a few minutes in traffic	☐	☐	☐	☐

Total Score: _____ *(Add columns 0-3)*

Patient Signature _____ Date _____

SLEEP STUDIES

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

☐ Home Sleep Study ☐ Polysomnographic evaluation performed at sleep disorder center

Sleep Center Name _____

Sleep Study Date _____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of
[ ] moderate obstructive sleep apnea
[ ] severe obstructive sleep apnea
[ ] mild obstructive sleep apnea

The evaluation showed

		during REM	*Supine*	*Side*
an RDI of	____	____	____	____
an AHI of	____	____	____	____

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:

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

Other _____ _____ _____

OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders?

__Yes __No Dieting
__Yes __No Weight loss
__Yes __No Surgery (Uvuloplasty)
__Yes __No Surgery (Uvulectomy)
__Yes __No Pillar procedure
__Yes __No Smoking cessation
__Yes __No CPAP
__Yes __No BiPap
__Yes __No Uvulectomy (but continues to have symptoms)
__Yes __No Uvuloplasty (but continues to have symptoms)

Other _____

_____

Patient Signature _____ Date _____

SLEEP HISTORY

Previous Diagnosis

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

If Yes, how long ago was it? _____ ☐ Years ago ☐ Months ago ☐ Days ago
number

Sleep:

How long does it take you to fall asleep? ____ minutes

Normally goes to bed at ___ ☐ AM ☐ PM

Hours of sleep per night ___ hours

Sleep aid ☐ Yes ☐ No

If yes, name that medication _____

__Yes __No Bruxism
__Yes __No Dry mouth
__Yes __No Excessive movements
__Yes __No Gasping
_____ Getting up <number of times> per night
__Yes __No Hypnagogic Hallucinations
__Yes __No Restless legs
__Yes __No Waking up and having difficulty returning to sleep
__Yes __No Dreaming
_____ Frequency of nocturnal urination (# of times)

Witnessed apneas are:

__Yes __No Worse during supine sleep
__Yes __No Worse following alcohol late at night

Wake

Sleepiness while driving ☐ Yes ☐ No

Risks discussed ☐ Yes ☐ No

The patient:

__Yes __No Awakens unrefreshed
__Yes __No Has morning headaches

_____ Naps
_____ (Choose ONE from below)
_____ naps daily
never naps
occasionally naps

Snoring is reported as:

_____ Frequency
_____ (Choose ONE from below)
_____ seldom
_____ never
daily
often

_____ Severity
_____ (Choose ONE from below)
_____ light
moderate
loud

__Yes __No Worse during supine sleep
__Yes __No Worse following alcohol late at night

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 _____

Medical History Questionnaire

OFFICE USE
Patient ID: _____

NAME: _____
First *Middle Initial* *Last*

FORM DATE: __/__/____

DATE OF BIRTH: _____

Address: _____

Phone Number: _____ Email: _____

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y ☐ N ☐	No known allergens	Y ☐ N ☐	Iodine	Y ☐ N ☐	Plastic
Y ☐ N ☐	Antibiotics	Y ☐ N ☐	Latex	Y ☐ N ☐	Sedatives
Y ☐ N ☐	Aspirin	Y ☐ N ☐	Local anesthetics	Y ☐ N ☐	Sleeping pills
Y ☐ N ☐	Barbiturates	Y ☐ N ☐	Metals	Y ☐ N ☐	Sulfa drugs
Y ☐ N ☐	Codeine	Y ☐ N ☐	Penicillin		

Other _____ _____ _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Medication name	Dosage/ Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Items: _____ _____

MEDICAL HISTORY: (Please indicate dates on items marked past)

Medical condition	Never	Current	Past	If past, enter date
Acid reflux	☐	☐	☐	_____
Adenoids Removed	☐	☐	☐	_____
Anemia	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Asthma	☐	☐	☐	_____
Autoimmune disorder	☐	☐	☐	_____
Arteriosclerosis	☐	☐	☐	_____
Bleeding easily	☐	☐	☐	_____
Blood pressure - High	☐	☐	☐	_____
Blood pressure - Low	☐	☐	☐	_____
Bruising easily	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Chemotherapy	☐	☐	☐	_____
Chronic cough	☐	☐	☐	_____
Chronic fatigue	☐	☐	☐	_____
Chronic pain	☐	☐	☐	_____
Chronic sinus problems	☐	☐	☐	_____
COPD	☐	☐	☐	_____
Cold hands and feet	☐	☐	☐	_____
CPAP	☐	☐	☐	_____

Medical condition	Never	Current	Past	If past, enter date
Insomnia	☐	☐	☐	_____
Intestinal disorders	☐	☐	☐	_____
Irregular heartbeat	☐	☐	☐	_____
Jaw joint surgery	☐	☐	☐	_____
Kidney problems	☐	☐	☐	_____
Liver disease	☐	☐	☐	_____
Low energy	☐	☐	☐	_____
Meniere's disease	☐	☐	☐	_____
Menstrual cramps	☐	☐	☐	_____
Mitral valve prolapse	☐	☐	☐	_____
Multiple sclerosis	☐	☐	☐	_____
Muscle aches	☐	☐	☐	_____
Muscle shaking (tremors)	☐	☐	☐	_____
Muscle spasms or cramps	☐	☐	☐	_____
Muscular dystrophy	☐	☐	☐	_____
Nasal allergies	☐	☐	☐	_____
Needing extra pillows to help breathing at night	☐	☐	☐	_____
Nervous system irritability	☐	☐	☐	_____
Nervousness	☐	☐	☐	_____

Patient Signature _____ Date _____

Medical condition	Never	Current	Past	If past, enter date
Current pregnancy	☐	☐	☐	_____
Depression	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Difficulty concentrating	☐	☐	☐	_____
Difficulty sleeping	☐	☐	☐	_____
Dizziness/Vertigo	☐	☐	☐	_____
Emphysema	☐	☐	☐	_____
Epilepsy	☐	☐	☐	_____
Excessive thirst	☐	☐	☐	_____
Fibromyalgia	☐	☐	☐	_____
Fluid retention	☐	☐	☐	_____
Frequent cough	☐	☐	☐	_____
Frequent illnesses	☐	☐	☐	_____
Frequent stressful situations	☐	☐	☐	_____
Gastrointestinal Reflux Disease (GERD)	☐	☐	☐	_____
General anesthesia	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Gout	☐	☐	☐	_____
Hay fever	☐	☐	☐	_____
Hearing impaired	☐	☐	☐	_____
Heart attack	☐	☐	☐	_____
Heart disorder	☐	☐	☐	_____
Heart murmur	☐	☐	☐	_____
Heart pacemaker	☐	☐	☐	_____
Heart palpitations	☐	☐	☐	_____
Heart valve replacement	☐	☐	☐	_____
Hemophilia	☐	☐	☐	_____
Hepatitis	☐	☐	☐	_____
Hypertension	☐	☐	☐	_____
Hypoglycemia	☐	☐	☐	_____
Immune system disorder	☐	☐	☐	_____
Injury to face	☐	☐	☐	_____
Injury to mouth	☐	☐	☐	_____
Injury to neck	☐	☐	☐	_____
Injury to teeth	☐	☐	☐	_____

Medical condition	Never	Current	Past	If past, enter date
Neuralgia	☐	☐	☐	_____
Numbness of fingers	☐	☐	☐	_____
Osteoarthritis	☐	☐	☐	_____
Osteoporosis	☐	☐	☐	_____
Ovarian cysts	☐	☐	☐	_____
Parkinson's disease	☐	☐	☐	_____
Poor circulation	☐	☐	☐	_____
Prior orthodontic treatment	☐	☐	☐	_____
Psychiatric care	☐	☐	☐	_____
Radiation treatment	☐	☐	☐	_____
Restless leg syndrome	☐	☐	☐	_____
Rheumatic fever	☐	☐	☐	_____
Rheumatoid arthritis	☐	☐	☐	_____
Scarlet fever	☐	☐	☐	_____
Scoliosis	☐	☐	☐	_____
Shortness of breath	☐	☐	☐	_____
Sinus problems	☐	☐	☐	_____
Skin disorder	☐	☐	☐	_____
Sleep apnea	☐	☐	☐	_____
Slow healing sores	☐	☐	☐	_____
Speech difficulties	☐	☐	☐	_____
Stroke	☐	☐	☐	_____
Swelling in ankles or feet	☐	☐	☐	_____
Swollen, stiff or painful joints	☐	☐	☐	_____
Tendency for frequent colds	☐	☐	☐	_____
Tendency for ear infections	☐	☐	☐	_____
Tendency for sore throats	☐	☐	☐	_____
Thyroid disorder	☐	☐	☐	_____
Tinnitis/Ringing in the ears	☐	☐	☐	_____
Tired muscles	☐	☐	☐	_____
Tonsils Removed	☐	☐	☐	_____
Tuberculosis	☐	☐	☐	_____
Tumors	☐	☐	☐	_____
Urinary disorders	☐	☐	☐	_____
Wisdom teeth extracted	☐	☐	☐	_____
Vertigo	☐	☐	☐	_____

Other	Current	Past	If past, enter date
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

Other	Current	Past	If past, enter date
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

ADDITIONAL MEDICAL HISTORY ITEMS:

	Never	Current	Past	If past, enter date
Recreational drugs	☐	☐	☐	_____

	Never	Current	Past	If past, enter date
HIV/AIDS	☐	☐	☐	_____

Patient Signature _____ Date _____

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

Y ☐ N ☐ Appendectomy	Y ☐ N ☐ Heart	Y ☐ N ☐ Thyroid
Y ☐ N ☐ Back	Y ☐ N ☐ Hernia repair	Y ☐ N ☐ Tonsillectomy
Y ☐ N ☐ Ear	Y ☐ N ☐ Lung	Y ☐ N ☐ Uvulectomy
Y ☐ N ☐ Gallbladder	Y ☐ N ☐ Nasal	Y ☐ N ☐ Periodontal
Other _____	_____	_____
_____	_____	_____

FAMILY HISTORY Has any member of you family had (parent, sibling or grandparent):

__Yes __No Cancer	__Yes __No Obesity
__Yes __No Heart disease	__Yes __No Thyroid disorder
__Yes __No Diabetes	__Yes __No Father snores
__Yes __No High blood pressure	__Yes __No Mother snores
__Yes __No Stroke	__Yes __No Father has sleep apnea
__Yes __No Sleep disorder	__Yes __No Mother has sleep apnea

SOCIAL HISTORY:

Patient's Occupation _____ Employer _____

Tobacco Use: Cigarettes ☐ Never smoked ☐ Current smoker # packs per day ____ # of years ____ ☐ Quit When did you quit? _____

Other tobacco: ☐ Pipe ☐ Snuff ☐ Cigar ☐ Chew

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No If yes, # of drinks per week: ____

Caffeine Intake: ☐ None ☐ Coffee/Tea/Soda # cups per day: ____

Additional:

__Yes __No Regular exercise _____ Number of children:

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