Version: SLPQV2

# Sleep Consultation

OFFICE USE
Patient ID:

NAME: _____ CURRENT DATE: ___/___/_____

DATE OF BIRTH: ___/___/_____ ☐ MALE ☐ FEMALE

**Referring Physician:** Contact ID:

## 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 | Number #1 = the most severe symptom | | Frequency 1-4 | Intensity 1-10 |
|---|---|---|---|---|---|---|---|
| ☐ | CPAP intolerance | ☐ | ☐ | ☐ | Gasping when waking up | ☐ | ☐ |
| ☐ | Difficulty falling asleep | ☐ | ☐ | ☐ | Nighttime choking spells | ☐ | ☐ |
| ☐ | Fatigue | ☐ | ☐ | ☐ | Significant daytime drowsiness | ☐ | ☐ |
| ☐ | Frequent heavy snoring | ☐ | ☐ | ☐ | Sleepiness while driving | ☐ | ☐ |
| ☐ | Frequent heavy snoring which affects the sleep of others | ☐ | ☐ | ☐ | Witnessed apneic events | ☐ | ☐ |

Other: Write In

Patient Signature: Date:

# 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 | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Sitting and reading |
| ☐ | ☐ | ☐ | ☐ | Watching TV |
| ☐ | ☐ | ☐ | ☐ | Sitting inactive in public place (e.g. 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 quietly after a lunch without alcohol |
| ☐ | ☐ | ☐ | ☐ | In a car, while stopped for a few minutes in traffic |

# Fatigue Scale

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

Total Score: ☐

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: __/__/____

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The evaluation confirmed a diagnosis of _____

The evaluation showed:

| | *during REM* | | *Supine* | *Side* |
|---|---|---|---|---|
| an RDI of | | | | |
| an AHI of | | | | |

a nadir $SpO_2$ of ____ T90 ____ ODI ____ (Oxygen Desaturation Index)

Slow Wave Sleep ☐ Decreased ☐ None

REM Sleep ☐ Decreased ☐ None

# Additional Questions

☐ Yes ☐ No Are you a current CPAP (Continuous Positive Air Pressure) user?

If Yes, what are the current CPAP settings: _____

# 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:**

☐ Mask leaks

☐ Inability to get the mask to fit properly

☐ Discomfort from headgear

☐ Disturbed or interrupted sleep

☐ Noise disturbing 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

☐ Latex allergy

☐ Claustrophobic associations

☐ An unconscious need to remove the CPAP

☐ Does not resolve symptoms

☐ Noisy

☐ Cumbersome

Other

_____

_____

_____

_____

# Other Therapy Attempts

**include:**

☐ Dieting

☐ Weight loss

☐ Surgery (Uvuloplasty)

☐ Surgery (Uvulectomy)

☐ Pillar procedure

☐ Smoking cessation

Patient Signature: _____ Date: _____

## Other Therapy Attempts

**include:**

- ☐ CPAP
- ☐ BiPap
- ☐ Uvulectomy (but continues to have symptoms)
- ☐ Uvuloplasty (but continues to have symptoms)

## History Of Treatment

| Practitioner's Name | Specialty | Treatment | Approximate Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Sleep History

**Previous Diagnosis**

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

If yes, how long ago was it? [ ] *number* ☐ Years ago ☐ Months ago ☐ Days ago

**Sleep:**

Sleep Onset Latency [ ] minutes

Normally goes to bed at [ ] ☐ AM ☐ PM

Hours of sleep per night [ ] hours

Sleep Aid ☐ Yes ☐ No

If yes, name the medication: [ ]

- ☐ Bruxism
- ☐ Dry mouth
- ☐ Excessive movements
- ☐ Gasping
- ☐ Hypnagogic Hallucinations
- ☐ Restless legs
- ☐ Waking up and having difficulty returning to sleep
- ☐ Dreaming

[ ] Getting up <number of times> per night

[ ] Frequency of nocturnal urination (# of times)

**Witnessed apneas are:**

☐ Worse during supine sleep ☐ Worse following alcohol late at night

Patient Signature: [ ] Date: [ ]

# Sleep History

**Wake**

Sleepiness while driving ☐ Yes ☐ No

Risks Discussed ☐ Yes ☐ No

The patient:

☐ Awakens unrefreshed

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**Snoring is reported as:**

Frequency
- ☐ seldom
- ☐ never
- ☐ daily
- ☐ often
- ☐ _____

Severity
- ☐ light
- ☐ moderate
- ☐ loud
- ☐ _____

- ☐ Worse during supine sleep
- ☐ Worse following alcohol late at night

# Patient Signature

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: _____