SLEEP SCREENING QUESTIONNAIRE

Please answer each question accurately and to the best of your knowledge. This will help us get an accurate picture of your health and sleep issues so that we may be able to provide you with the best possible treatment.

Patient Information

DATE: _______________

☐ *MR.* ☐ *MS.* ☐ *MISS* *NAME:* ____
☐ *MRS.* ☐ *DR.* *FIRST* *MIDDLE INTIAL* *LAST*

AGE: ____________________________ *BIRTH DATE:* ______________ ☐ *MALE* ☐ *FEMALE*

ADDRESS: ____

CITY/STATE/ZIP: ____

HOW LONG AT CURRENT ADDRESS? __________*(IF LESS THEN THREE YEARS, PLEASE GIVE PREVIOUS ADDRESS)*

PREVIOUS ADDRESS: ____

EMPLOYED BY: ____

ADRESS: ____

SS#: ____________________ *HOME PHONE:* ________________________ *WORK PHONE:* ______________________

CELL PHONE: _________________________ *EMAIL:* ____

RESPONSIBLE PARTY: ____

FAMILY PHYSICIAN: ____

ADRESS: ____

FAMILY DENTIST: ____

ADRESS: ____

Please list other health care practitioners seen in the last 9 months: ___________________________________

____

INSURANCE

MEMBER NUMBER _________________________________

GROUP NUMBER _________________________________

PLAN NUMBER __________________________________

*NAME OF PRIMARY CARE PHYSICIAN*_________________________________

HEIGHT: __________*feet* ________*inches*

WEIGHT: __________*pounds*

REFERRED BY: ____

WHAT ARE THE CHIEF COMPLAINTS YOU ARE SEEKING TREATMENT FOR?

Please number the complaints with #1 being the most important.

___ *Frequent heavy snoring*
  ___ *which affects the sleep of others.*
___ *Significant daytime drowsiness*
___ *I have been told "I stop breathing" when sleeping.*
___ *Difficulty falling asleep*
___ *Waking up gasping*
___ *Feeling un-refreshed in the morning*
___ *Morning hoarseness*
___ *Morning headaches*
___ *Swelling in ankles or feet*
___ *Nocturnal teeth grinding*
___ *Jaw pain*
___ *Facial Pain*
___ *Jaw clicking*

Other: _________________________________ _________________________________

Patient Signature ______________________________________ *Date* ___________________________________

List any medications that have caused an allergic reaction:

Y☐ N☐ Antibiotics
Y☐ N☐ Metals
Y☐ N☐ Aspirin
Y☐ N☐ Penicillin
Y☐ N☐ Barbiturates

Y☐ N☐ Plastic
Y☐ N☐ Codeine
Y☐ N☐ Sedatives
Y☐ N☐ Iodine
Y☐ N☐ Sleeping Pills
Y☐ N☐ Latex

Y☐ N☐ Sulfa drugs
Y☐ N☐ Local anesthetics
Others ________________
____
____

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 Medicine
Y☐ N☐ High blood pressure medicine
Y☐ N☐ Insulin
Y☐ N☐ Muscle relaxants
Y☐ N☐ Nerve (anxiety) 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☐ Heart pacemaker
Y☐ N☐ Osteoarthritis
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Heart valve replacement
Y☐ N☐ Osteoporosis
Y☐ N☐ Asthma
Y☐ N☐ Heartburn
Y☐ N☐ Poor circulation
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Orthodontic treatment
Y☐ N☐ Bleed easily
Y☐ N☐ Hepatitis
Y☐ N☐ Recent weight gain
Y☐ N☐ Sinus problems
Y☐ N☐ High blood pressure
Y☐ N☐ Chronic fatigue
Y☐ N☐ Immune system disorder
Y☐ N☐ Rheumatic fever
Y☐ N☐ Congestive heart failure
Y☐ N☐ Headaches

Y☐ N☐ Injury to Face or Neck
Y☐ N☐ TMJ treatment
Y☐ N☐ Shortness of breath
Y☐ N☐ Current pregnancy
Y☐ N☐ Swollen/Stiff/Painful joints
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Insomnia
Y☐ N☐ Thyroid problems
Y☐ N☐ Dizziness
Y☐ N☐ Irregular heart beat
Y☐ N☐ Tonsils removed
Y☐ N☐ Emphysema
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Wisdom teeth extraction
Y☐ N☐ Epilepsy
Y☐ N☐ Low blood pressure
Y☐ N☐ Fibromyalgia
Y☐ N☐ Memory loss
Y☐ N☐ Frequent sore throats
Y☐ N☐ Migraines

Y☐ N☐ Gastric Reflux (GERD)
Y☐ N☐ Morning dry mouth
Y☐ N☐ Hay fever
Y☐ N☐ Muscle cramps
Y☐ N☐ Heart disorder
Y☐ N☐ Needing extra pillows to sleep at night
Y☐ N☐ Heart murmur
Y☐ N☐ Irregular heart beat
Y☐ N☐ Heart pounding
Y☐ N☐ Nighttime sweating

Other medical history:
____
____
____
____
____
____
____
____

Patient Signature ______________________________ Date ______________________________

Sleep Center Evaluation

Have you ever had an Overnight Sleep Study? Yes ☐ No ☐

If yes:

Sleep Center Name ______________________________

Location ______________________________

Sleep Study Date ______________________

FOR OFFICE USE ONLY	
The evaluation confirmed a diagnosis of obstructive sleep apnea:	☐ *Mild* ☐ *Moderate* ☐ *Severe*
The evaluation showed an RDI of ________ *and an AHI of* ________	

CPAP Intolerance

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 because:

- ☐ *The mask leaks*
- ☐ *I was unable to get the mask to fit properly*
- ☐ *Of discomfort caused by the straps and/or headgear*
- ☐ *Of disturbed or interrupted sleep caused by the presence of the device*
- ☐ *Noise from the device disrupts my sleep and /or my bed partner's sleep*
- ☐ *It restricted my movements during sleep*
- ☐ *It does not seem to be effective*
- ☐ *Pressure on the upper lip caused tooth related problems*
- ☐ *I have a latex allergy*
- ☐ *It made me feel claustrophobic*
- ☐ *I had 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, lap band, smoking cessation for at least one month, surgeries, oral appliances, etc.)

____

____

____

Patient Signature ______________________________ *Date* ______________________

Family History

1. *Have any members of your family (blood kin) had:* *Yes ☐ No ☐ Heart Disease*
   Yes ☐ No ☐ High blood pressure
   Yes ☐ No ☐ Diabetes

2. *Have any immediate family members been diagnosed or treated for a sleep disorder?* *Yes ☐ No ☐*

Social History

Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?

☐ *Never* ☐ *Occasionally* ☐ *Once/week* ☐ *Several days/week* ☐ *Daily*

Sedative consumption: How often do you take sedatives(including sleeping pills) within 2-3 hours of bedtime?

☐ *Never* ☐ *Occasionally* ☐ *Once/week* ☐ *Several days/week* ☐ *Daily*

Caffeine consumption: How often do you consume caffeine within 2-3 hours of bedtime?

☐ *Never* ☐ *Occasionally* ☐ *Once/week* ☐ *Several days/week* ☐ *Daily*

Do you smoke? ☐ *Yes* ☐ *No* *If yes, enter the number of packs/day:*____________

Do you use any tobacco products? ☐ *Yes* ☐ *No*

I authorize the release of a full report of examination, findings, diagnosis, treatment programs, 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 fees for treatment regardless of insurance coverage.

Patient Signature ____ *Date* ________________________

Berlin Questionnaire Sleep Evaluation

Category 1

1. Complete the following:

Height________ Age__________________

Weight_______ Male/Female___________

2. Do you Snore?

Yes

No

Don't know

If you snore:

3. Your snoring is?

Slightly louder than breathing

As loud as talking

Louder than talking

Very loud. Can be heard in adjacent rooms

4. How often do you snore?

Nearly every day

3-4 times a week

1-2 times a week

1-2 times a month

Never or nearly never

5. Has your snoring ever bothered other people?

Yes

No

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

Nearly every day

3-4 times a week

1-2 times a week

1-2 times a month

Never or nearly never

Category 2

7. How often do you feel tired or fatigued after your sleep?

Nearly every day

3-4 times a week

1-2 times a week

1-2 times a month

Never or nearly never

8. During you waketime, do you feel tired, fatigued or not up to par?

Nearly every day

3-4 times a week

1-2 times a week

1-2 times a month

Never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?

Yes

No

If yes, how often does it occur?

Nearly every day

3-4 times a week

1-2 times a week

1-2 times a month

Never or nearly never

Category 3

10. Do you have high blood pressure?

Yes

No

Don't know

(For office use)
Scoring Questions: Any answer in "Bold" is a positive response

Scoring categories:
Category 1 is positive with 2 or more positive responses to questions 2-6
Category 2 is positive with 2 or more positive responses to questions 7-9
Category 3 is positive with 1 positive response and/or a BMI > 30 (BMI= Body Mass Index)

Final Result: 2 or more possible categories indicate a high likelihood of sleep disordered breathing.

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	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a 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	☐	☐	☐	☐

Total Score: ______________
(Add columns 0-3)

Patient Signature ________________________________ *Date* ________________________________

AFFIDAVIT FOR INTOLERANCE TO CPAP

Name____

I have attempted to use CPAP therapy to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reason(s):

________Mask Leaks

________Mask uncomfortable/Device uncomfortable

________Unable to sleep comfortably

________Noise disturbs my sleep and/or bed partner's sleep

________Restricts movement during sleep

________Does not seem to be effective

________Straps/headgear cause discomfort

________Pressure on the upper lip causes tooth related problems

________Other____

Because of my intolerance/inability to use CPAP therapy, I wish to have an alternative method of treatment. That form of therapy is an Oral Airway Dilator appliance, as prescribed to me by Dr. Jonathan Greenburg, DDS.

Patient Signature ________________________________ *Date* ______________________________

ACKNOWLEDGEMENT OF TREATMENT

I, ________________________________, understand that I am not being treated by the doctors of Snore No More for any dental diseases or conditions of the mouth. I am only seeking treatment for snoring and / or Sleep Apnea, and I see a dentist regularly for all my dental care.

Patient Signature ____________________________________ *Date* ________________________________

Witness ______________________________

RECORDS RELEASE REQUEST

Date___________________

To: ____

Address: ____

City: ______________________ *State:* ___________ *Zip:* _______

I authorize the release of medical and/or dental records, or copies of such, transferred to:

Dr. Jonathan Greenburg, DDS, FAGD
5363 Balboa Blvd., Suite 245
Encino, CA 91316
(818) 457-6673   Fax (818) 386-8963

☐ *Please Fax*   ☐ *Please Mail*

☐ *Sleep Study*   ☐ *Dental Records*   ☐ *Medical History*

____

Print Name of Patient   *Patient's Date of Birth*

____

Signature of Patient or Guardian