

# 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: \_\_\_\_\_      WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_      EMAIL: \_\_\_\_\_

RESPONSIBLE PARTY: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

FAMILY DENTIST: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

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

\_\_\_\_\_

<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:

- |   |  |                        |
|---|--|------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Antibiotics       | <input type="checkbox"/> Y <input type="checkbox"/> N Metals         | Other allergens: _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin           | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin     | _____                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates      | <input type="checkbox"/> Y <input type="checkbox"/> N Plastic        | _____                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine           | <input type="checkbox"/> Y <input type="checkbox"/> N Sedatives      | _____                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Iodine            | <input type="checkbox"/> Y <input type="checkbox"/> N Sleeping pills | _____                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Latex             | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfa drugs    | _____                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Local anesthetics |  |                        |

## List any medications you are currently taking:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Antacids                                 | <input type="checkbox"/> Y <input type="checkbox"/> N Codeine                        | <input type="checkbox"/> Y <input type="checkbox"/> N Pain medication |
| <input type="checkbox"/> Y <input type="checkbox"/> N Antibiotics                              | <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone                      | <input type="checkbox"/> Y <input type="checkbox"/> N Sleeping pills  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anticoagulants                           | <input type="checkbox"/> Y <input type="checkbox"/> N Diet pills                     | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfa drugs     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Antidepressants                          | <input type="checkbox"/> Y <input type="checkbox"/> N Heart medication               | <input type="checkbox"/> Y <input type="checkbox"/> N Tranquilizers   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anti-inflammatory drugs<br>(non-steroid) | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure medication |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates                             | <input type="checkbox"/> Y <input type="checkbox"/> N Insulin                        | Other current medications: _____                                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood thinners                           | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle relaxants               | _____   |
|  | <input type="checkbox"/> Y <input type="checkbox"/> N Nerve pills                    | _____   |

## Medical History

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia  | <input type="checkbox"/> Y <input type="checkbox"/> N Heart pacemaker  | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoarthritis                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arteriosclerosis  | <input type="checkbox"/> Y <input type="checkbox"/> N Heart valve replacement  | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis                        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma  | <input type="checkbox"/> Y <input type="checkbox"/> N Heartburn or a sour taste<br>in the mouth at night                       | <input type="checkbox"/> Y <input type="checkbox"/> N Poor circulation                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune disorders                                      | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis  | <input type="checkbox"/> Y <input type="checkbox"/> N Prior orthodontic treatment         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding easily   | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure  | <input type="checkbox"/> Y <input type="checkbox"/> N Recent excessive weight<br>gain     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chronic sinus problems                                    | <input type="checkbox"/> Y <input type="checkbox"/> N Immune system disorder   | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic fever                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chronic fatigue   | <input type="checkbox"/> Y <input type="checkbox"/> N Injury to<br><input type="checkbox"/> Face <input type="checkbox"/> Neck | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congestive heart failure                                  | <input type="checkbox"/> Y <input type="checkbox"/> N Insomnia   | <input type="checkbox"/> Y <input type="checkbox"/> N Swollen, stiff or painful<br>joints |
| <input type="checkbox"/> Y <input type="checkbox"/> N Current pregnancy   | <input type="checkbox"/> Y <input type="checkbox"/> N Irregular heart beat   | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid problems                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes  | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw joint surgery  | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillectomy (have had)            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty concentrating                                  | <input type="checkbox"/> Y <input type="checkbox"/> N Low blood pressure   | <input type="checkbox"/> Y <input type="checkbox"/> N Wisdom teeth extraction             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness   | <input type="checkbox"/> Y <input type="checkbox"/> N Memory loss  | Other medical history:<br>_____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema   | <input type="checkbox"/> Y <input type="checkbox"/> N Migraines  | _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy  | <input type="checkbox"/> Y <input type="checkbox"/> N Morning dry mouth  | _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fibromyalgia  | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle spasms or<br>cramps   | _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent sore throats                                     | <input type="checkbox"/> Y <input type="checkbox"/> N Needing extra pillows to<br>help breathing at night                      |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Gastroesophageal Reflux<br>Disease (GERD)                 | <input type="checkbox"/> Y <input type="checkbox"/> N Nighttime sweating   |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay fever   |  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart disorder  |  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur  |  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart pounding or beating<br>irregularly during the night |  |   |

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      Yes     No   
or treated for a sleep disorder?

# Social History

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

- Never       Once a week       Several days a week       Daily       Occasionally

Sedative consumption: How often do you take sedatives within 2-3 hours of bedtime?

- Never       Once a week       Several days a week       Daily       Occasionally

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

- Never       Once a week       Several days a week       Daily       Occasionally

Do you smoke?     Yes     No      If yes, enter the number of packs per day (or other description of quantity):

\_\_\_\_\_

Do you use chewing tobacco?     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

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

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 your 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

10. Do you have high blood pressure?

- yes  
 no  
 don't know

(For office use)

Scoring Questions: Any answer within the box outline 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 indicates a high likelihood of sleep disordered breathing.

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

Date \_\_\_\_\_

Berlin

# 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 (e.g. 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 stopped 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 \_\_\_\_\_