



Dear Patient,

The following questionnaire has many questions related to sleep and other aspects of your health that may have an impact on your sleep. Please complete this form to the best of your abilities. The aim of this questionnaire is to be as thorough as reasonable to assess our ability to provide proper care for your sleep health, and we need your help in order to achieve this.

If you don't see the point of some questions, please feel free to ask the dentist at the time of your consultation. Thank you for your help.

## Personal Information

Name	_____	Today's date	_____
Address	_____	Phone	(    ) _____
e-mail	_____	Date of Birth	_____
Occupation	_____	Age	_____
Referred by	_____	Address (city)	_____
Physician	_____	Address (city)	_____
Dentist	_____	Address (city)	_____
Specialist	_____	Address (city)	_____

Please **rate from 1 to 3**, in order of importance to you, the top three reasons you are here today.

Problems with sleep \_\_\_\_\_

Snoring bothering bed-partner \_\_\_\_\_

Snoring bothering you \_\_\_\_\_

Daytime sleepiness or fatigue \_\_\_\_\_

Don't want to wear CPAP \_\_\_\_\_

Cannot tolerate CPAP \_\_\_\_\_

Other \_\_\_\_\_

## Medical History

Do you have any of the following problems? (CHECK ALL THAT APPLY)

<input type="checkbox"/> Allergies	<input type="checkbox"/> COPD	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Post-nasal drip
<input type="checkbox"/> Angina	<input type="checkbox"/> Depression	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney or liver disease	<input type="checkbox"/> Sinusitis or Rhinitis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Leg cramps while asleep	<input type="checkbox"/> Stroke or CVA
<input type="checkbox"/> Back problems	<input type="checkbox"/> Fibromyalgia syndrome	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Bypass surgery	<input type="checkbox"/> GERD	<input type="checkbox"/> Morning headaches	<input type="checkbox"/> Visual disturbance
<input type="checkbox"/> Chronic fatigue syndrome	<input type="checkbox"/> Heartburn (reflux)	<input type="checkbox"/> Neurological disease	<input type="checkbox"/> Other
<input type="checkbox"/> Sensitivity to metals			

Your height is \_\_\_\_\_ ft. \_\_\_\_\_ in. Your weight is \_\_\_\_\_ pounds BMI

Office use

Please list all the medications that you take and the doses, prescription and over the counter.

_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications?  Yes  No

If yes, please list: \_\_\_\_\_

On average, how much alcohol do you drink per week?

\_\_\_\_\_ Beer                      \_\_\_\_\_ Glasses of wine                      \_\_\_\_\_ Ounces of liquor

On average how much caffeine do you take in each day?

\_\_\_\_\_ Cups of coffee                      \_\_\_\_\_ Cups of tea                      \_\_\_\_\_ Cans of cola

Do you presently smoke?  Yes  No

Have you smoked in the past?  Yes  No

If yes, how many cigarettes a day on average? \_\_\_\_\_

If yes, how long ago did you quit? \_\_\_\_\_

## Sleep History

Have you ever had a sleep study?  Yes  No

If yes, when was it done? Date: \_\_\_\_\_ Where? \_\_\_\_\_

Have you tried CPAP?  Yes  No

Do you use CPAP now?  Yes  No

How long have you used it? \_\_\_\_\_ years.

Have you tried other treatments? Describe. \_\_\_\_\_

Office use			
PSG with patient	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnostic	<input type="checkbox"/> Titration <input type="checkbox"/>
Study date		AHI	
Provider		RDI	
CPAP tried	<input type="checkbox"/> Yes <input type="checkbox"/> No	H2O cm.	
SaO2 nadir			
Phase related	<input type="checkbox"/> Yes <input type="checkbox"/> No	Positional	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have **non-restorative sleep**? (feeling not rested/ refreshed/ restored in the morning in spite of getting adequate amount of sleep)  Yes  No If yes, how many times per month? \_\_\_\_\_ /30

Do you have **trouble falling asleep**?  Yes  No If yes, how many times per month? \_\_\_\_\_ /30

Do you have **trouble staying asleep**?  Yes  No If yes, how many times per month? \_\_\_\_\_ /30

*For each of the following statements, please choose the response that best describes your sleep over the past month:*

I have had **difficulties getting up** in the morning.

Never  Rarely  Sometimes  Often

I wake up **not feeling rested**.

Never  Rarely  Sometimes  Often

I have felt **as if I have not slept long enough**, even after having enough time in bed.

Never  Rarely  Sometimes  Often

I feel **refreshed after sleep**.

Never  Rarely  Sometimes  Often

What is your usual bedtime? \_\_\_\_\_

What time do you usually get up? \_\_\_\_\_

How many times per night do you get out of bed? \_\_\_\_\_

How many times do you need to use the bathroom each night? \_\_\_\_\_

## Sleep History (Continued)

Please check all that apply. **Please try to be thorough and complete** in order to help provide a clear picture of your sleep history. *Check the box if this describes **half the time or more***

<input type="checkbox"/>	You have trouble falling asleep	<input type="checkbox"/>	You sleep alone
<input type="checkbox"/>	You waken often at night	<input type="checkbox"/>	You sleep with a bed partner
<input type="checkbox"/>	You have trouble falling back to sleep	<input type="checkbox"/>	You awaken with a dry throat
<input type="checkbox"/>	You nap	<input type="checkbox"/>	You have headaches on awakening
<input type="checkbox"/>	You prefer to sleep on your back	<input type="checkbox"/>	You drool while sleeping
<input type="checkbox"/>	You prefer to sleep on your side	<input type="checkbox"/>	You have ever awakened choking
<input type="checkbox"/>	You prefer to sleep on your stomach	<input type="checkbox"/>	You have ever awakened gasping
<input type="checkbox"/>	You <b>do not</b> have a regular bedtime	<input type="checkbox"/>	You have acid reflux at night only
<input type="checkbox"/>	You use the bathroom more than once a night	<input type="checkbox"/>	You have family members who have apnea
<input type="checkbox"/>	You use medications to help you sleep	<input type="checkbox"/>	You have had adult orthodontics
<input type="checkbox"/>	Your nose is stuffy going to bed	<input type="checkbox"/>	You have a history of grinding or clenching
<input type="checkbox"/>	You have a history of jaw pain	<input type="checkbox"/>	You have a history of gum disease
<input type="checkbox"/>	You work shifts	<input type="checkbox"/>	You sometimes get swollen ankles

## Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

*0 = would never doze*

*2 = moderate chance of dozing*

*1 = slight chance of dozing*

*3 = high chance of dozing*

Situation	Chance of dozing (0-3)
<b>Sitting and reading</b>	
<b>Watching TV</b>	
<b>Sitting, inactive in a public place ( e.g. theatre or a meeting)</b>	
<b>As a passenger in a car for an hour without a break</b>	
<b>Lying down to rest in the afternoon when circumstances permit</b>	
<b>Sitting and talking to someone</b>	
<b>Sitting quietly after a lunch without alcohol</b>	
<b>In a car, while stopped for a few minutes in the traffic.</b>	
<b>TOTAL</b>	

## Fatigue Severity Scale

Please circle the number between 1 and 7 which you feel best fits the following statements. This refers to your usual way of life within the last week.

During the past week, I have found that:	Completely Disagree		Neither Agree Nor Disagree			Completely Agree	
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7

Office Use	
<b>Total:</b>	Average Total divided by 9 =

## STOP BANG

Do you Snore?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel tired, fatigued or sleepy during the day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone Observed you stop breathing in your sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No

STOP Total

Office Use	Neck size? _____ cm.	BMI = _____ Kg./m <sup>2</sup>
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Office use			
B	A	N	G
<b>BMI</b>	<b>Age</b>	<b>Neck Size</b>	<b>Gender</b>
>35	>50 yr.	>40 cm. >15.7"	=Male

Stop Bang Total

BMI = 35 if...

Height	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76
Weight	167	173	179	185	191	197	204	210	216	223	230	236	243	250	258	265	272	279	287

*By signing this document I certify that I have provided accurate answers to the above questions to the best of my ability. I understand that providing inaccurate answers may be dangerous to my health and result in inappropriate treatment. I authorize Dr. Farquhar to perform diagnostic procedures as may be required to provide necessary treatment. I understand that information provided from, or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the services for myself is mine, and I assume responsibility for fees associated with these services.*

X \_\_\_\_\_ Date: \_\_\_\_\_  
 (signature)

Reviewed by treating dentist \_\_\_\_\_ Date: \_\_\_\_\_

### Oral examination

TMJ sounds	yes / no	Number of teeth	adequate / inadequate
TMJ history	yes / no	Oral hygiene	adequate / inadequate
Mallampati class'n	1 2 3 4	Periodontal condition	adequate / inadequate
Tongue grade	1 2 3	Dental condition	adequate / inadequate
Range of motion	adequate / inadequate	Pharyngeal width	narrow /normal
Protrusive range	mm.	Tonsil grade	1 2 3 4
Vestibular space	adequate / inadequate	Uvula size	normal / large

### Summary

Office Use	Score
AHI	
BMI	
Epworth	
Fatigue Scale	
STOP BANG	

# OFFICE USE ONLY

Date: \_\_\_\_\_

Assessment:

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Plan:

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Letters:

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Body Mass Index Table																																																							
Normal                      Overweight                      Obese                      Extreme Obesity																																																							
BMI	19 20 21 22 23 24				25 26 27 28 29					30 31 32 33 34 35 36 37 38 39										40 41 42 43 44 45 46 47 48 49 50 51 52 53 54																																			
Height (inches)	Body Weight (pounds)																																																						
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258																			
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267																			
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276																			
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285																			
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295																			
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	276	282	287	293	299	304																			
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314																			
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324																			
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334																			
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344																			
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354																			
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365																			
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376																			
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386																			
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397																			
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408																			
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420																			
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431																			
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443																			