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?

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

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

Other: Write In

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

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 quietly after a lunch without alcohol
☐	☐	☐	☐	In a car, while stopped for a few minutes in traffic

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: ____/____/_____

FOR OFFICE USE ONLY

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

Patient Signature: _____ Date: _____

CPAP Intolerance

(Continuous Positive Airway Pressure device)

Other

Other Therapy Attempts

include:

- ☐ Dieting
- ☐ Weight loss
- ☐ Surgery (Uvuloplasty)
- ☐ Surgery (Uvulectomy)
- ☐ Pillar procedure
- ☐ Smoking cessation
- ☐ 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

☐ Gasping

☐ Getting up <# of times> per night

Sleep Aid ☐ Yes ☐ No

If yes, name the medication:

☐ Bruxism (grinding teeth)

☐ Dry mouth

☐ Excessive movements

Patient Signature: Date:

Sleep History

Witnessed apneas are:

- ☐ Worse when sleeping on your back
- ☐ Worse following alcohol late at night

Wake

Sleepiness while driving ☐ Yes ☐ No

Risks Discussed ☐ Yes ☐ No

The patient:

- ☐ Awakens unrefreshed
- ☐ Has morning headaches

Naps

- ☐ naps daily
- ☐ never napping
- ☐ occasionally naps
- ☐ rarely naps

Snoring is reported as:

Frequency

- ☐ seldom
- ☐ never
- ☐ daily
- ☐ often

- ☐ Worse when sleeping on your back
- ☐ Worse following alcohol late at night

Severity

- ☐ light
- ☐ moderate
- ☐ loud

Patient Signature

I authorize the release of a full report of examination findings, diagnosis, treatme nt program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insura nce companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regar dless of insurance coverage.

Patient Signature: _____ Date: _____

I certify that the medical history information is complete and accurate.

Patient Signature: _____ Date: _____