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SLEEP QUESTIONNAIRE FOR DIAGNOSED SLEEP APNEA PATIENTS

Dr. Darrell Morden DDS Diplomate, American Board of Dental Sleep Medicine

PLEASE SET ASIDE TIME TO COMPLETE THIS FORM ACCURATELY **Date :**_____

How did you hear about Our Clinic?

☐ Google Ad ☐ Internet Search ☐ Doctor Referral ☐ Friend Referral ☐ Existing patient ☐ Other:

PERSONAL INFORMATION

Mr. Ms. Mrs. Dr. First_____ Last_____

Date of Birth: _____ Age:_____ Best Tele Number:_____

Home Address: _____

Family Physician/Walk-in:_____AHS Care #_____

Family Dentist/Clinic:_____

Specialist Doctors:_____

Pharmacy: _____

E-mail: _____ Phone Number: _____

As applicable

☐ we may request and review a CPAP compliance report or sleep record from physician (if applicable)

☐ we have provided youour privacy agreement/ medical authorization form

CHIEF COMPLAINTS / REASONS FOR CONSULTATION _____

☐ Snoring / Loud	☐ Snoring affects sleep of others	☐ Bed partner separation
☐ Daytime drowsiness	☐ Fell asleep driving / at work	☐ Causing problem at work
☐ Unrefreshing sleep	☐ Interrupted sleep	☐ Awakening from sleep
☐ Unable to sleep on back	☐ Choking/gasping in sleep	☐ Witnessed stopped breathing
☐ Difficulty falling asleep	☐ Difficulty staying asleep	☐ Waking short of breath
☐ Morning hoarseness	☐ Morning headaches	☐ Morning fogginess
☐ Memory / concentration	☐ Depression/anxiety	☐ Insomnia
☐ Feeling tired / low energy	☐ Losing appetite / or over-eating	☐ Restless legs / limb movement's

☐ Problem with other therapy attempts (eg. CPAP, weight loss programs, nasal rinse, snore guards, etc)

☐ Sleep bruxism/grinding/clenching

SLEEP CENTRE EVALUATION(S)

Previous Sleep Clinic or Sleep Physician evaluation(s)? ○YES ○NO

If yes, list Clinic/Doctor _____Year:_____ Overnight study: ☐Home ☐In-Lab

Diagnosis List ☐ Sleep Apnea ☐ Mild ☐ Moderate ☐ Severe ☐ Night-time Oxygen problem ☐ Snoring

☐ Insomnia ☐ Restless Legs / limb movemt's ☐ Parasomnias (sleep walking) ☐ Narcolepsy

If an ENT / Surgeon consulted for sinus/airway concerns? Name _____

Previous Insomnia / Cognitive-behavioral interventions? ○Yes ○No Where:_____

THERAPY ATTEMPTS

☐CPAP / PAP	☐ Nasal Surgery	☐Uvuloplasty / PPP
☐ Nasal Strips	☐ Nasal Spray/Rinse	☐ Nasal Dilators
☐ Side Sleeping/tennis ball	☐ Elevated bedframe	☐ Special Pillow
☐ Weight loss program	☐ Avoiding alcohol	☐ Store-bought / dental device

CPAP (CONTINUOUS POSITIVE AIRWAY PRESSURE) HISTORY

☐ I did a trial of CPAP ☐ I purchased a CPAP device Year:_____ Location:_____

☐ I am or ☐ I am not currently using the device or ☐ I am not using it enough to be effective

If in use, average hours/night worn: ☐ 1-3 ☐ 4-6 ☐ 7-9+

I sleep better using CPAP? ○Yes ○No

I feel more refreshed the next morning having used CPAP ○ Yes ○ No

Last use of the machine: _____

☐ I tried different types like ☐ Basic/constant pressure ☐ AutoPAP ☐ BiPAP

☐ I tried different masks/interfaces like ☐ nasal pillow ☐ full=nose mask ☐ full mouth/nose mask

☐ I travel a lot and need a more convenient alternative

Current CPAP Pressure Setting: _____ (if known)

(See next for CPAP problems list)

CPAP INTOLERANCE / PROBLEMS

☐ Uncomfortable	☐ Claustrophobia	☐ Painful to wear
☐ Poor sleep with device	☐ Restricted movement in sleep	☐ Strap/headgear pressure
☐ Fit problem / mask leak	☐ Cumbersome	☐ Air in stomach/chest
☐ Pressure hurts throat	☐ Pressure hurts ribs	☐ Doesn't feel effective
☐ Nasal congestion problem	☐ Allergies/congestion worsened	☐ Sinus problems
☐ Latex allergy	☐ Grinding/clenching going on	☐ Teeth / TMJ joints / face hurts
☐ Noisy to bed partner	☐ Partner's sleep disturbed	☐ Dry Mouth / throat / sore
☐ Other:		

SLEEP HISTORY / NORMAL HABITS

Normal bedtime:_____ Normal wake-up time: _____

Time takes to fall asleep:_____ min/hours

Times awakened at night: _____

Difficulty returning to sleep? ○ Yes ○ No Typical time it takes to return to sleep _____ min/hr

Do you dream ☐ Often ☐ Irregularly ☐ Rarely ☐ Vividly ☐ Full recall ☐ Night terrors

Sleep aid / medication? ○ Yes ○ No

Napping ☐ Daily ☐ Rarely ☐ Excessively ☐ Daydream

Awakenings/Interrupted sleep caused by:

☐ Snoring	☐ Hunger / Thirst	☐ Full bladder/bathroom needs
☐ Choking / Gasping	☐ Headache	☐ Grinding / clenching
☐ Heartburn	☐ Nightmares / sweats	☐ Anxiety / worry
☐ Noise	☐ Bed-Partner/kids/pets	☐ Pain (source_____)
☐ CPAP problem	☐ Restless Legs / limbs	☐ Unknown reason
☐ Witnessed apneas	☐ Worse when sleeping on back	☐ Worse with evening alcohol

DAYTIME SLEEPINESS PROBLEMS (EPWORTH SLEEPINESS SCALE)

How likely are you to doze off or fall asleep in the following situations?

(Even if not a recent thing, think on how they ***would have affected you*** in these specific examples)

	No Chance	Possibly	Would have	Yes definitely	
Sitting and reading	0	1	2	3	_____
Watching TV / Movie	0	1	2	3	_____
Sitting inactive (Meeting, Theatre)	0	1	2	3	_____
As a passenger a car for an hour	0	1	2	3	_____
Lying down to rest in the afternoon	0	1	2	3	_____
Sitting and talking to someone	0	1	2	3	_____
Sitting quiet after lunch, no alcohol	0	1	2	3	_____
In a car, stopped in traffic	0	1	2	3	_____

SOCIAL HISTORY

Occupation/Vocational Training:_____ ? ☐ Professional Driver

☐Employed ☐ Retired ☐ Looking for work ☐ Student ☐Other:_____

Alcoholic beverage ☐Daily ☐ Weekly ☐ Rarely ☐ Never ☐ Before sleep ☐problematic ☐ history

Caffeine beverage ☐Daily ☐ Weekly ☐ Rarely ☐ Never ☐ Before sleep ☐problematic ☐history

Nicotine/replacement ☐ Daily ☐ Weekly ☐ Rarely ☐ Never ☐ Before sleep ☐ problematic ☐ history

CBD/THC/Marijuana ☐ Daily ☐ Weekly ☐ Rarely ☐ Never ☐ Before sleep ☐ problematic ☐ history

Evening consumption ☐Alcohol ☐ Caffeine ☐ Nicotine ☐ CBD/THC ☐ Food

SHIFT WORK? ◯Yes ◯No ☐ Inconsistently ☐ Long-term ☐ Work-schedule effects sleep schedule

SLEEP DEPRIVATION ◯Yes ◯No ☐ Inconsistently ☐ Long-term

CLINIC USE	
HT _____in _____cm	Neck Circ _____in_____cm
WT _____ lb _____kg	O2SAT _____
BMI _____	BP _____
MALLAMPATI 1 / 2 / 3 / 4	PAL VAULT shallow / steep
TONGUE high / retracted / enlarged	CROWDING dental / pharyngeal conditions
TMJ joint noise / history of concern	NASAL breathing patent / obstruction / surgeries
Number of teeth	PERIO / Hygiene likely wnL / concern
PSG / Sleep Study - Available	Gag Reflex report

_____ _____

Signature Date

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Consent for Disclosure of Personal Information

info@westcalgarydentalgroup.com

I, _____, consent to the release of
(Name)

_____
(Identify nature of personal information)

to _____
(Identify individual/organization to whom information is released)

from _____
(Indicate where information is transferring from)

_____

I acknowledge that I have been made aware of the reasons for the disclosure of the above information, and the risks and benefits associated with consenting or not consenting to its release.

I understand that I make revoke my consent at any time, by providing a signed, written statement to my West Calgary Dental Group.

E-mail: _____ Telephone Number: _____

Signature: _____ Print Name: _____

Date: _____