Sleep Consultation

OFFICE USE
Patient ID: _____

NAME: _____ TODAY'S DATE _____
First *Middle Initital* *Last*

DATE OF BIRTH: _____ ☐ MALE ☐ FEMALE

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

TMD / PAIN COMPLAINTS
____ Difficulty Swallowing
____ Dizziness
____ Facial Pain
____ Headaches
____ Jaw Clicking
____ Jaw Locking
____ Jaw Pain
____ Limited Mouth Opening
____ Migraines
____ Morning Head Pain
____ Morning Hoarseness
____ Neck Pain
____ Nocturnal Teeth Grinding
____ Pain when Chewing

Number
#1 = the most severe symptom

____ Ringing in the Ears

SLEEP BREATHING COMPLAINTS
____ CPAP Intolerance
____ Difficulty Falling Asleep
____ Fatigue
____ Frequent Heavy Snoring
____ Frequent Heavy Snoring Which Affects the Sleep of Others
____ Gasping when Waking Up
____ Nighttime Choking Spells
____ Significant Daytime Drowsiness
____ Sleepy while Driving
____ Witnessed Apneic Events

PERIODONTAL COMPLAINTS
____ Bleeding gums
____ Hallitosis (Bad Breath)

Other - Write in:

____ _____ _____ _____
____ _____ _____ _____

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:

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

Other _____ _____ _____

Patient Signature _____ Date _____

SLEEP STUDIES

Have you ever had an evaluation at a Sleep Center? ☐ Yes ☐ No

Sleep Center Name and Location _____

_____

Sleep Study Date _____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of ☐ mild ☐ moderate ☐ severe obstructive sleep apnea

The evaluation showed

		during REM	*Supine*	*Side*
an RDI of	_____	_____	_____	_____
an AHI of	_____	_____	_____	_____

a nadir SpO2 of _____ T90 _____

Slow Wave Sleep ☐ Decreased ☐ None

REM Sleep ☐ Decreased ☐ None

OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders?

__Yes __No Dieting

__Yes __No Weight loss

__Yes __No Surgery (Uvuloplasty)

__Yes __No Surgery (Uvulectomy)

__Yes __No Pillar procedure

__Yes __No Smoking cessation

__Yes __No CPAP

__Yes __No BiPap

__Yes __No Uvulectomy (but continues to have symptoms)

__Yes __No Uvuloplasty (but continues to have symptoms)

__Yes __No The patient will consider oral appliance therapy and will call to schedule an appointment to proceed if he wishes to pursue treatment

Other _____

_____

Patient Signature _____ Date _____

THE EPWORTH SLEEPINESS SCALE

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

✓ 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 (i.e. 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 quitely after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopping for a few minutes in traffic	☐	☐	☐	☐

Total Score: _____ *(Add columns 0-3)*

FATIGUE SCALE

During the past week:	**No <<** 1	2	3	4	5	6	7 **>> Yes**
I felt fatigued and had less motivation	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and did not desire to exercise	☐	☐	☐	☐	☐	☐	☐
I felt fatigued often	☐	☐	☐	☐	☐	☐	☐
I felt fatigue that interfered with my physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which caused me frequent problems	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which prevented sustained physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and couldn't carry out certain duties and responsibilities	☐	☐	☐	☐	☐	☐	☐
Fatigue was among my three most disabling symptoms	☐	☐	☐	☐	☐	☐	☐
Fatigue interfered with my work, family or social life	☐	☐	☐	☐	☐	☐	☐

Total Score: ____

Patient Signature _____ Date _____

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or trating 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 charges for treatment to me regardless of insurance coverage.

Patient Signature _____ Date _____

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

Patient Signature _____ Date _____