

Sleep Consultation

OFFICE USE Patient ID: _____

NAME: _____
First Middle Initial Last

CURRENT DATE: __/__/__

DATE OF BIRTH: _____ MALE FEMALE

Referring Physician: _____

Number

Continued...

#1 = the most severe symptom

- _____ 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
- _____ Sleepiness while driving
- _____ Witnessed apneic events

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 (i.e. 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 stopping 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 _____

FATIGUE SCALE

During the past week:

No <<

>> Yes

	1	2	3	4	5	6	7
I felt fatigued and had less motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued and did not desire to exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigue that interfered with my physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued which caused me frequent problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued which prevented sustained physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued and couldn't carry out certain duties and responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue was among my three most disabling symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue interfered with my work, family or social life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score: _____

Berlin Questionnaire Sleep Evaluation

category 1

1. Complete the following:

Height ___ ft ___ in

Weight ___ Age ___

2. Do you snore?

- yes
- no
- don't know

If you snore: (Answer questions 3-6)

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

category 2

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

category 3

(For office use)

Scoring Questions: Any answer within the box 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

Score: ___

(BMI = Body Mass Index)

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

SLEEP STUDIES

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

Home Sleep Study Polysomnographic evaluation performed at sleep disorder center

Sleep Center Name _____

Sleep Study Date _____

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The evaluation confirmed a diagnosis of moderate obstructive sleep apnea

severe obstructive sleep apnea

The evaluation showed mild obstructive sleep apnea

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

a nadir SpO2 of _____ T90 _____ ODI (Oxygen Desaturation Index)

Slow Wave Sleep Decreased None

REM Sleep Decreased None

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 Does not resolve symptoms

__Yes __No Noisy

__Yes __No Cumbersome

Other _____

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)

Other _____

Patient Signature _____ Date _____

SLEEP HISTORY

Previous Diagnosis

Yes No Have you been previously diagnosed with Obstructive Sleep Apnea?

If Yes, how long ago was it? _____ Years ago Months ago Days ago
number

Sleep:

How long does it take you to fall asleep? _____ minutes

Normally goes to bed at _____ AM PM

Hours of sleep per night _____ hours

Sleep aid Yes No

If yes, name that medication _____

___Yes ___No Bruxism

___Yes ___No Dry mouth

___Yes ___No Excessive movements

___Yes ___No Gasping

_____ Getting up <number of times> per night

___Yes ___No Hypnagogic Hallucinations

___Yes ___No Restless legs

___Yes ___No Waking up and having difficulty returning to sleep

___Yes ___No Dreaming

_____ Frequency of nocturnal urination (# of times)

Witnessed apneas are:

___Yes ___No Worse during supine sleep

___Yes ___No Worse following alcohol late at night

Wake

Sleepiness while driving Yes No

_____ Risks discussed Yes No

The patient:

___Yes ___No Awakens unrefreshed

___Yes ___No Has morning headaches

_____ Naps

_____ (Choose ONE from below)

_____ naps daily

_____ never napping

_____ occasionally naps

Snoring is reported as:

_____ Frequency

_____ (Choose ONE from below)

_____ seldom

_____ never

_____ daily

_____ often

_____ Severity

_____ (Choose ONE from below)

_____ light

_____ moderate

_____ loud

___Yes ___No Worse during supine sleep

___Yes ___No Worse following alcohol late at night

I authorize the release of a full report of examination findings, diagnosis, treatment program 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 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 _____