Version: SLPQV2

Sleep Consultation

OFFICE USE
Patient ID: _____

NAME: _____ CURRENT DATE: __/__/____
First *Middle Initial* *Last*

DATE OF BIRTH: _____ ☐MALE ☐FEMALE

Referring Physician: _____

Number
#1 = the most severe symptom

____ CPAP intolerance
____ Difficulty falling asleep
____ Fatigue
____ Frequent heavy snoring
____ Frequent heavy snoring which affects the sleep of others

____ _____
____ _____
____ _____

Continued...

____ 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 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: ____

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

category 3

10. Do you have high blood pressure?
    - ☐ yes
    - ☐ no
    - ☐ don't know

(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.

Patient Signature _____ Date _____

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
[ ] mild obstructive sleep apnea

The evaluation showed

		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 _____