midtown.
SLEEP + AIRWAY

SLEEP CONSULTATION QUESTIONNAIRE

Dear Patient,

The following form has many questions related to sleep and other aspects of your health that may have an impact on the quality of your sleep. Please complete this form to the best of your abilities. The aim of this questionnaire is to be as thorough as possible to assess our ability to provide proper care for your sleep health.If there are any questions you are unsure of, please feel free to ask the dentist at the time of your consultation.

Thank you for your help.

Dr. Sylvie Renoir

Patient Information:

Name: _____ Phone: _____

Address: _____

Email: _____ Date of Birth: _____

Occupation: _____ Age: _____

AHC #: _____

Referred By:

Physician: _____ City: _____

Dentist: _____ City: _____

Specialist: _____ City: _____

Self Referral: ☐ Respiratory Clinic: _____

Please rate from 1 to 3, in order of importance, the top three reasons that bring you to our clinic, with 1 being the most important, and 3 being the least.

Snoring bothering bed-partner: ☐
Snoring bothering you: ☐
Daytime sleepiness or fatigue: ☐
Don't want to wear CPAP: ☐
Cannot tolerate CPAP: ☐
Problems with sleep: ☐
Other (Explain):

Medical History:

Do you have any of the following problems? Check all that apply.

- ☐ Allergies
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Back problems
- ☐ Bypass surgery
- ☐ Chronic fatigue syndrome
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Eye Disease
- ☐ Fibromyalgia syndrome
- ☐ GERD
- ☐ Heart disease
- ☐ Heartburn (reflux)
- ☐ High blood pressure
- ☐ Kidney or liver disease
- ☐ Leg cramps while asleep
- ☐ Migraine headaches
- ☐ Morning headaches
- ☐ Neurological disease
- ☐ Post-nasal drip
- ☐ PTSD
- ☐ Seizure disorder
- ☐ Sensitivity to metals
- ☐ Sinusitis or Rhinitis
- ☐ Stroke or CVA
- ☐ Thyroid disease
- ☐ Visual disturbance
- ☐ Other (Explain):

Body Info:

Height: _____ ft. _____ in. Weight: _____ lbs.

BMI: * _____ *For Office Use Only.

Medical History:

Please list all the medications that you take and the doses. Including prescription, vitamins, supplements, and over the counter.

_____ _____

_____ _____

Are you allergic to any medications? ☐No ☐Yes (Please List): _____

On average, how much alcohol do you drink per week?

☐ Beers ☐ Glasses of Wine ☐ Ounces of liquor

On average, how much caffeine do you take in each day?

☐ Cups of Coffee ☐ Cups of Tea ☐ Cans of Cola

Do you currently smoke? ☐No ☐Yes If yes, how many cigarettes per day on average? _____

Have you smoked in the past? ☐No ☐Yes If yes, how long ago did you quit? _____

Sleep History:

Have you ever had a sleep study? ☐No ☐Yes If yes, when was it done? _____ Where? _____

Have you tried CPAP? ☐No ☐Yes

Do you use CPAP now? ☐No ☐Yes How long have you used it? _____ years.

Have you tried other treatments? Describe. _____

Do you have non-restorative* sleep? ☐No ☐Yes If yes, how many times per month? _____ /30
(*feeling not rested / refreshed / restored in the morning in spite of getting adequate amount of sleep)

Do you have trouble falling asleep? ☐No ☐Yes If yes, how many times per month? _____ /30

Do you have trouble staying asleep? ☐No ☐Yes If yes, how many times per month? _____ /30

For each of the following statements, please choose the response that best describes your sleep over the past month:

	Never	Rarely	Sometimes	Often
I have had difficulties getting up in the morning.	○	○	○	○
I wake up not feeling rested.	○	○	○	○
I have felt as if I have not slept long enough, even after having enough time in bed.	○	○	○	○
I feel refreshed after sleep.	○	○	○	○

What is your usual bedtime? _____

What time do you usually get up? _____

How many times per night do you get out of bed? _____

How many times do you need to use the bathroom each night? _____

For Office Use: Total: _____

Sleep History:

Please check all that apply. **Please try to be thorough** and complete in order to help provide a clear picture of your sleep history. Check the box if this describes **half the time or more.**

- ☐ You have trouble falling asleep
- ☐ You sleep alone
- ☐ You waken often at night
- ☐ You sleep with a bed partner
- ☐ You have trouble falling back to sleep
- ☐ You awaken with a dry throat
- ☐ You nap
- ☐ You have headaches on awakening
- ☐ You prefer to sleep on your back
- ☐ You drool while sleeping
- ☐ You prefer to sleep on your side
- ☐ You wake up choking
- ☐ You prefer to sleep on your stomach
- ☐ You have awakened gasping
- ☐ You do not have a regular bedtime
- ☐ You have acid reflux at night only
- ☐ You use the bathroom more than once a night
- ☐ You have family members who have apnea
- ☐ You use medications to help you sleep
- ☐ You have had adult orthodontics
- ☐ Your nose is stuffy going to bed
- ☐ You have a history of grinding or clenching
- ☐ You have a history of jaw pain
- ☐ You have a history of gum disease
- ☐ You work shifts
- ☐ You sometimes get swollen ankles
- ☐ You have had tonsils or adenoids removed

Fatigue Severity Scale

Please check the number between 1 and 7 which you feel best fits the following statements. This refers to your usual way of life within the last week.

	Completely Disagree			Neither Agree Nor Disagree			Completely Agree
My motivation is lower when I am fatigued.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
Exercise brings on my fatigue.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
I am easily fatigued.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
Fatigue interferes with my physical functioning.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
Fatigue causes frequent problems for me.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
My fatigue prevents sustained physical functioning.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
Fatigue interferes with carrying out certain duties & responsibilities.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
Fatigue is among my three most disabling symptoms.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
Fatigue interferes with my work, family, or social life.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

STOP BANG:

Office Use:
Avg. Total / 9 = _____

Do you **s**nore?	☐ No	☐ Yes
Do you feel **t**ired, fatigued or sleepy during the day?	☐ No	☐ Yes
Has anyone **o**bserved you stop breathing in your sleep?	☐ No	☐ Yes
Do you have high blood **p**ressure?	☐ No	☐ Yes

Office Use: Neck Size: _____ cm. BMI: _____ Kg./m^2

Office Use: **B**MI > 35 **A**ge > 50 **N**eck Size > 40 cm > 15.7" **G**ender = Male

BMI = 35 if

Height	58	59	60	61	62	63	64	65	66	67	68	69	71	72	73	74	75	76
Weight	167	173	185	191	197	204	210	216	223	230	236	243	250	258	265	272	279	287

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

Chance of Dozing 0-3	Situation
_____	Sitting and reading
_____	Watching TV
_____	Sitting, inactive in a public place (e.g. theatre of 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 quietly after a lunch without alcohol
_____	In a car, while stopped for a few minutes in traffic.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

_____ **TOTAL**

By signing this document I certify that I have provided accurate answers to the above questions to the best of my ability. I understand that providing inaccurate answers may be dangerous to my health and result in inappropriate treatment. I authorize Dr. Renoir to perform diagnostic procedures as may be required to provide necessary treatment. I understand that information provided from, or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the services for myself is mine, and I assume responsibility for fees associated with these services.

Patient Signature: _____ Date: _____

Reviewed by treating dentist: _____ Date: _____

For Office Use: Oral Examination:

TMJ Sounds	☐ No	☐ Yes	Number of Teeth	☐ Adequate	☐ Inadequate
TMJ History	☐ No	☐ Yes	Oral Hygiene	☐ Adequate	☐ Inadequate
Mallampati Class'n	☐ 1 ☐ 2 ☐ 3 ☐ 4		Periodontal Condition	☐ Adequate	☐ Inadequate
Tongue Grade	☐ 1 ☐ 2 ☐ 3		Dental Condition	☐ Adequate	☐ Inadequate
Range of Motion	_____ mm.	☐ Adequate ☐ Inadequate	Pharyngeal Width	☐ Narrow	☐ Normal
Protrusive Range	_____ mm.		Tonsil Grade	☐ 1 ☐ 2 ☐ 3 ☐ 4	
Vestibular Space	☐ Adequate	☐ Inadequate	Uvula Size	☐ Normal ☐ Large	☐ Long
Tongue Tie	☐ No	☐ Yes	Deviated Septum	☐ No	☐ Yes

Office Use Only:

Date: _____

Summary:

AHI _____
BMI _____
Epworth _____
Fatigue Scale _____
STOP BANG _____

Assessment:

Plan:

Letters: