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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: _____