

Sleep Consultation

| |
|---------------------------------|
| OFFICE USE Patient ID: _____ |
|---------------------------------|

NAME: _____

CURRENT DATE: ___/___/___

First Middle Initial Last

DATE OF BIRTH: _____ MALE FEMALE

Referring Physician: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

2. Then rate your complaints for frequency and intensity:

Frequency

1-SELDOM 2-OCCASIONAL 3-FREQUENT
4-EVERYDAY

Intensity

0=NO PAIN and 10 is MOST SEVERE PAIN

| Number | Frequency | Intensity | Continued... | Frequency | Intensity |
|--|-----------|-----------|--------------------------------------|-----------|-----------|
| | | | | | |
| <i>#1 = the most severe symptom</i> | | | | | |
| _____ CPAP intolerance | _____ | _____ | _____ Gasping when waking up | _____ | _____ |
| _____ Difficulty falling asleep | _____ | _____ | _____ Nighttime choking spells | _____ | _____ |
| _____ Fatigue | _____ | _____ | _____ Significant daytime drowsiness | _____ | _____ |
| _____ Frequent heavy snoring | _____ | _____ | _____ Sleepiness while driving | _____ | _____ |
| _____ Frequent heavy snoring which affects the sleep of others | _____ | _____ | _____ Witnessed apneic events | _____ | _____ |
| <i>Other - Write in:</i> | | | | | |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

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 _____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of AHJ in normal range (<5)
 extremely severe

The evaluation showed moderate obstructive sleep apnea
 severe obstructive sleep apnea
 mild obstructive sleep apnea

| | <i>during REM</i> | <i>Supine</i> | <i>Side</i> |
|-----------------|-------------------|---------------|-------------|
| 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:

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mask leaks | <input type="checkbox"/> Yes <input type="checkbox"/> No Pressure on the upper lip causing tooth related problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Inability to get the mask to fit properly | <input type="checkbox"/> Yes <input type="checkbox"/> No Latex allergy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Discomfort from headgear | <input type="checkbox"/> Yes <input type="checkbox"/> No Claustrophobic associations |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Disturbed or interrupted sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No An unconscious need to remove the CPAP |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Noise disturbing sleep and/or bed partner's sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No Does not resolve symptoms |
| <input type="checkbox"/> Yes <input type="checkbox"/> No CPAP restricted movements during sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No Noisy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No CPAP does not seem to be effective | <input type="checkbox"/> Yes <input type="checkbox"/> 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)

__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 _____

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 _____

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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: _____

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 _____