

Sleep Screening Questionnaire



This questionnaire was designed to provide important facts regarding the history of your sleep condition. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible. Please sign each page.

Patient Information

Today's Date: _____

Mr ☐ Ms ☐ Miss ☐ Name: _____
Mrs ☐ Dr ☐ First Middle Initial Last

Age: _____ Birthdate _____ Male ☐ Female ☐

Address: _____

City/State/Zip: _____

Employed By: _____

Address: _____

SS#: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Responsible Party: _____

Family Physician: _____ City/State _____

Family Dentist: _____ City/State _____

Primary Medical Insurance Information

Primary Insured First Name _____ Last Name _____ MI _____

Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other ☐

Insurance ID number _____ Group Number _____

Insured Soc Sec Number _____ Insured Birth Date _____

Secondary Medical Insurance Information

Primary Insured First Name _____ Last Name _____ MI _____

Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other ☐

Insurance ID number _____ Group Number _____

Insured Soc Sec Number _____ Insured Birth Date _____

Referred by: _____

Patient Signature (or parent if child)

Date

List any Medications which have caused an allergic reaction:

- | | | | |
|--|---|---|--|
| ☐ Y ☐ N Antibiotics | ☐ Y ☐ N Codeine | ☐ Y ☐ N Local anesthetics | ☐ Y ☐ N Sedatives |
| ☐ Y ☐ N Aspirin | ☐ Y ☐ N Iodine | ☐ Y ☐ N Metals | ☐ Y ☐ N Sleeping pills |
| ☐ Y ☐ N Barbiturates | ☐ Y ☐ N Latex | ☐ Y ☐ N Penicillin | ☐ Y ☐ N Sulfa Drugs |

Other allergens: _____

List any Medications currently being taken:

Medication Name	Dose/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History

- | | | |
|--|---|---|
| ☐ Y ☐ N Acid Reflux (GERD) | ☐ Y ☐ N Gout | ☐ Y ☐ N Nasal allergies |
| ☐ Y ☐ N Anemia | ☐ Y ☐ N Hay fever | ☐ Y ☐ N Needing extra pillows to help breath at night |
| ☐ Y ☐ N Arteriosclerosis | ☐ Y ☐ N Hearing impaired | ☐ Y ☐ N Nervous system irritability |
| ☐ Y ☐ N Arthritis | ☐ Y ☐ N Heart attack | ☐ Y ☐ N Nervousness |
| ☐ Y ☐ N Asthma | ☐ Y ☐ N Heart disorder | ☐ Y ☐ N Neuralgia |
| ☐ Y ☐ N Autoimmune Disorder | ☐ Y ☐ N Heart murmur | ☐ Y ☐ N numbness of fingers |
| ☐ Y ☐ N Bleed easily | ☐ Y ☐ N Heart pacemaker | ☐ Y ☐ N Osteoarthritis |
| ☐ Y ☐ N Blood Pressure (High Low) | ☐ Y ☐ N Heart palpitations | ☐ Y ☐ N Osteoporosis |
| ☐ Y ☐ N Bruise easily | ☐ Y ☐ N Heart valve replacement | ☐ Y ☐ N Ovarian cyst |
| ☐ Y ☐ N Cancer | ☐ Y ☐ N Hemophilia | ☐ Y ☐ N Parkinson's disease |
| ☐ Y ☐ N Chemotherapy | ☐ Y ☐ N Hepatitis | ☐ Y ☐ N Poor circulation |
| ☐ Y ☐ N Chronic cough | ☐ Y ☐ N Hypertension | ☐ Y ☐ N Prior orthodontic treatment |
| ☐ Y ☐ N Chronic fatigue | ☐ Y ☐ N Hypoglycemia | ☐ Y ☐ N Psychiatric care |
| ☐ Y ☐ N Chronic pain | ☐ Y ☐ N Immune system disorder | ☐ Y ☐ N Radiation treatment |
| ☐ Y ☐ N Cold hands and feet | ☐ Y ☐ N Injury to | ☐ Y ☐ N Rheumatic fever |
| ☐ Y ☐ N COPD | ☐ Face ☐ Neck | ☐ Y ☐ N Rheumatoid arthritis |
| ☐ Y ☐ N Depression | ☐ Head ☐ Mouth ☐ Teeth | ☐ Y ☐ N Scarlet fever |
| ☐ Y ☐ N Diabetes | ☐ Y ☐ N Insomnia | ☐ Y ☐ N Scoliosis |
| ☐ Y ☐ N Difficulty concentrating | ☐ Y ☐ N Intestinal disorders | ☐ Y ☐ N Shortness of breath |
| ☐ Y ☐ N Difficulty sleeping | ☐ Y ☐ N Jaw joint surgery | ☐ Y ☐ N Sinus problems |
| ☐ Y ☐ N Dizziness | ☐ Y ☐ N Kidney problems | ☐ Y ☐ N Skin disorder |
| ☐ Y ☐ N Emphysema | ☐ Y ☐ N Liver disease | ☐ Y ☐ N Sleep apnea |
| ☐ Y ☐ N Epilepsy | ☐ Y ☐ N Low energy | ☐ Y ☐ N Speech difficulties |
| ☐ Y ☐ N Excessive thirst | ☐ Y ☐ N Meniere's disease | ☐ Y ☐ N Stroke |
| ☐ Y ☐ N Fibromyalgia | ☐ Y ☐ N Menstrual cramps | ☐ Y ☐ N Swelling in ankles of feet |
| ☐ Y ☐ N Fluid retention | ☐ Y ☐ N Multiple sclerosis | ☐ Y ☐ N Thyroid disorder (High Low) |
| ☐ Y ☐ N Frequent cough | ☐ Y ☐ N Muscle aches | ☐ Y ☐ N Tonsils/Adenoids removed |
| ☐ Y ☐ N Frequent stressful situation | ☐ Y ☐ N Muscle shaking (tremors) | ☐ Y ☐ N Tuberculosis |
| ☐ Y ☐ N General Anesthesia | ☐ Y ☐ N Muscle spasms or cramps | ☐ Y ☐ N Tumors |
| ☐ Y ☐ N Glaucoma | ☐ Y ☐ N Muscular dystrophy | ☐ Y ☐ N Urinary disorders |

Patient Signature _____

Date _____

VISTANCIA ORTHODONTICS

Please list any other medical conditions not listed above: _____

List any surgical operations you have had:

- | | | |
|---|--|--|
| ☐ Y N Appendectomy | ☐ Y N Hernia repair | ☐ Y N Sinus Surgery |
| ☐ Y N Back | ☐ Y N Knee Surgery | ☐ Y N Stent implant/heart |
| ☐ Y N Ear | ☐ Y N Lung | ☐ Y N Thyroid |
| ☐ Y N Gallbladder | ☐ Y N Nasal | ☐ Y N Tonsillectomy |
| ☐ Y N Heart | ☐ Y N Periodontal | ☐ Y N Uvulectomy |

Other _____

Family History (has any member of your family had - parent, sibling or grandparent)

- | | |
|--|---|
| ☐ Y N Cancer | ☐ Y N Obesity |
| ☐ Y N Heart Disease | ☐ Y N Thyroid trouble |
| ☐ Y N Diabetes | ☐ Y N Father snores |
| ☐ Y N High Blood pressure | ☐ Y N Mother snores |
| ☐ Y N Stroke | ☐ Y N Father has sleep apnea |
| ☐ Y N Sleep Disorder | ☐ Y N Mother has sleep apnea |

Other _____

Social History:

Tobacco Use: Cigarettes ☐ Never smoked ☐ Current smoker ☐ Quit ☐
packs per day _____ When did you quit? _____

of years
Other: Pipe ☐ Snuff ☐ Cigar ☐ Chew ☐

Alcohol Use: Do you drink alcohol? Yes ☐ No ☐ if yes, # drinks per week _____

Caffeine Intake: None ☐ Coffee/Tea/Soda ☐ # cups per day _____

Regular Exercise: Yes ☐ No ☐

Sedatives: Do you use within 2-3 hours of bedtime? Yes ☐ No ☐ Times/Week _____

Patient Signature _____ Date _____

Sleep Consultation



Name: _____
First Middle Initial Last

Today's Date _____

Date of Birth: ____/____/____

☐ Male ☐ Female

What Are Your Chief Complaints For Which You Are Seeking Treatment?

Please number your complaints with #1 being the most severe, #2 the next most severe, etc. You may assign the same number for more than once. You do not need to number every item, only those which present as your chief concerns.

SLEEP BREATHING COMPLAINTS

- ☐ CPAP Intolerance
- ☐ Daytime Tiredness
- ☐ Difficulty Falling Asleep
- ☐ Fatigue
- ☐ Decreased Concentration
- ☐ Depression
- ☐ High Blood Pressure
- ☐ Gasping When Waking Up
- ☐ Loud Snoring
- ☐ Never Feel Rested
- ☐ Nighttime Choking Spells
- ☐ Obesity
- ☐ Significant Daytime Drowsiness
- ☐ Sleep While Driving
- ☐ Witnessed Apnea Events
- ☐ Frequent Heavy Snoring

TMD/PAIN COMPLAINTS

- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Facial Pain
- ☐ Headaches
- ☐ Jaw Clicking
- ☐ Jaw Locking
- ☐ Jaw Pain
- ☐ Limited Mouth Opening
- ☐ Migraines
- ☐ Morning Head Pain
- ☐ Morning Hoarseness
- ☐ Neck Pain
- ☐ Nocturnal Teeth Grinding
- ☐ Pain When Chewing
- ☐ Ringing in the Ears
- ☐ Frequent Heavy Snoring affecting
Sleep of Others

Patient Signature _____

Date _____

Sleep Studies



Have you ever had an evaluation at a Sleep Center? Y ☐ N ☐

If Yes, Please complete the "Sleep Records Request Form" on the Next Page

Have you been previously diagnosed with Obstructive Sleep Apnea?

If yes, how long ago was it? _____ Years Ago ☐ Months Ago ☐ Days Ago ☐

Other Therapy Attempts

What other therapies have you had for breathing disorders?

Y	N	
☐	☐	Dieting
☐	☐	Weight Loss
☐	☐	Surgery (Uvuloplasty)
☐	☐	Surgery (Uvulectomy)
☐	☐	Pillar procedure
☐	☐	Smoking Cessation
☐	☐	CPAP
☐	☐	BiPAP
☐	☐	Uvulectomy (but continues to have symptoms)
☐	☐	Uvuloplasty (but continues to have symptoms)

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:

Y	N	
☐	☐	Mask Leaks
☐	☐	Inability to get the mask to fit properly
☐	☐	Discomfort from headgear
☐	☐	Disturbed or Interrupted sleep
☐	☐	Noise disturbing sleep and/or bed partner's sleep
☐	☐	CPAP restricts movements during sleep
☐	☐	CPAP does not seem to be effective
☐	☐	Pressure on the upper lip causing tooth related problems
☐	☐	Latex allergy
☐	☐	Claustrophobic associations
☐	☐	An unconscious need to remove the CPAP
☐	☐	unable to sleep well
☐	☐	Does not resolve symptoms
☐	☐	Noisy
☐	☐	Cumbersome
☐	☐	Other:

Patient Signature _____

Date _____ 5

Berlin Questionnaire Sleep Evaluation

1. Complete the following:

height _____ age _____

weight _____ male/female _____

2. Do you snore?

☐ yes

☐ no

☐ don't know

If you snore:

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

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

(For office use)

Scoring Questions: Any answer within the box outline 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 ☐

(BMI = Body Mass Index)

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

VISTANCIA ORTHODONTICS

Patient Name: _____ Date: _____

Age: _____ DOB: _____ Height: _____ ft

Weight: _____ lbs Neck Size: _____ in Waist Size _____ in

Using the scale provided, please answer how likely you are to doze off or fall asleep in the following situations:

0 = Would Never Doze
1 = Slight Chance of Dozing
2 = Moderate Chance of Dozing
3 = High Chance of Dozing

Sitting and reading	_____
Watching TV	_____
Sitting inactive in a movie/meeting	_____
Riding in a car as a passenger for more than an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total	_____

Please mark if you suffer from or have been told you have any of the following:

☐ Loud Snoring	☐ Frequent Nighttime Urination	☐ Diabetes
☐ Witnessed Apnea	☐ Daytime Tiredness	☐ COPD
☐ Obesity/Weight Gain	☐ Depression	☐ Thyroid Dysfunction
☐ Waking up Coughing	☐ High Blood Pressure	☐ Lack of Energy
☐ Never Feel Rested	☐ Headaches in Morning	☐ CPAP Intolerance
☐ Acid Reflux	☐ Decreased Concentration	

For Women Only:		
☐ Pregnant	☐ Postmenopausal	☐ Polycystic Ovary Syndrome
☐ Premenopausal	☐ Hysterectomy	

For Office Use Only-----

Enlarged Tonsils:

No ☐
Yes ☐
What Size _____

BMI _____
Blood Pressure _____ Pulse _____

Mallampati Classification

Class 1 _____
Class 2 _____
Class 3 _____
Class 4 _____



Patient Signature _____

Date _____



For you to receive the most complete care, it is important for doctors to communicate with one another about the treatment they are providing. Please provide the names and addresses of any doctors with which you would like us to share your progress notes and diagnostic reports.

I authorize the release of a full report of examination findings, diagnosis, treatment programs, 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 fees for treatment regardless of insurance coverage.

Patient Signature _____ DOB _____ Date _____

Please put the doctor's name and addresses below:

If you do not know the address please write office crossroads

Dentist: _____

Primary Care Physician: _____

Specialist 1: _____

Specialist 2: _____

Specialist 3: _____

For Office use only

Initial Visit _____ Release Visit _____ Chief Complaints _____ %reduced _____
BMI _____ Neck _____ Waist _____ ESS _____ %reduced _____
%reduced _____

AHI Beg _____ End _____ Prev dx by _____
ODI Beg _____ End _____ Prev dx date _____

CPAP Intolerance due to _____ Reports: CB ☐ Initial HST ☐ Final HST ☐
_____ Appliance type _____ Del Date _____ 9 _____