Sleep Disorder Screen

Which of the following CONDITIONS have you experienced? Medications for condition

☐ High Blood Pressure ☐ High Cholesterol ☐ Stroke _____

☐ Coronary Artery Disease ☐ Congestive Heart Failure _____

☐ Irregular Heart rhythms (atrial fibrillation) ☐ Heart Attack ☐ Other Heart Disease _____

☐ Mood Disorders ☐ Depression ☐ Anxiety _____

☐ Insomnia ☐ Narcolepsy _____

☐ GERD/Acid Reflux ☐ ADD/ADHD ☐ Fibromyalgia _____

☐ Diabetes ☐ Obesity ☐ Cancer _____

☐ Lung Disorders (COPD, Emphysema, etc) _____

Which of the following SYMPTOMS have you experienced?

☐ Someone has told you that you snore ☐ Do you awaken from Sleep with Chest Pain or Shortness of Breath

☐ Someone has told you that you stopped breathing during sleep ☐ You awakened Gasping for air

☐ Restless Sleep ☐ Non-refreshing Sleep / Still feel tired after sleep ☐ Frequent Awakening during Sleep

☐ Daytime Sleepiness ☐ Difficulty Concentrating ☐ Impaired Cognition ☐ Restless Leg ☐ Fatigue during the Day

☐ Morning Dry Mouth ☐ Morning Sore Throat ☐ Morning Headaches ☐ Decreased Intimacy

☐ Short Tempered ☐ Lack of Energy ☐ Clinching/Grinding/Bruxism ☐ Unintentional Dozing / Falling Asleep

☐ Consume more than 2 (8oz) sources of caffeine daily

Have you already had a previous Sleep Study?

☐ No ☐ Yes _____

Have you already been diagnosed with Sleep Apnea?_____

What treatments have you tried?_____

Do you utilize your Treatment every Sleep Session for the duration of the sleep session? _____

PATIENT INFORMATION

DOB / / ☐ **Male** ☐ **Female**

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ Zip Code: _____

Cell: _____ / _____ / _____ Work: _____ / _____ / _____ Home: _____ / _____ / _____

Height: _____ ft. _____ in. Weight: _____lbs. Neck Size:_____in.

X_____ Date: / /

it is best to have your significant others present or at least consider their answers as you consider the following:

EPWORTH SLEEP QUESTIONNAIRE

How likely are you to doze/fall asleep while?	Never	Slight	Moderate	High
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e. a theatre or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3

Total Score: _____

Primary Care Physician:

Name: _____

Address: _____

Phone: _____ Fax: _____

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Intolerance or Non-Compliance to PAP Therapy

1) I have attempted to use PAP (Positive Air Pressure) to manage my sleep related breathing disorder (OSA-Obstructive Sleep Apnea) and find it intolerable **or**
2) I would know it to be intolerable to use on a regular basis for the following reason(s), **or**
3) I desire to add Oral Appliance to my PAP Regimen to try and help the following issues:

- ❑ Mask Leaks; not a good seal
- ❑ Uncomfortable Pressure of the forced air
- ❑ An Inability to get the mask to fit properly/comfortably
- ❑ Discomfort caused by the straps and headgear
- ❑ Disturbed or interrupted sleep caused by the presence of the device
- ❑ Device disturbing sleep or bed partner's sleep
- ❑ PAP restricted movements during sleep
- ❑ PAP does not seem to be effective
- ❑ Pressure on the upper lip causes tooth related problems
- ❑ Latex allergy
- ❑ Claustrophobic associations
- ❑ An unconscious need to remove the PAP apparatus at night
- ❑ Other _____

Because of my intolerance / inability to use the PAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Advancement Device

Signed: _____

Dated: _____

A general dentist with emphasis on Solutions for Sleep Disorder Breathing
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