Version: SLPQV1

Sleep Screening Questionnaire

OFFICE USE
Patient ID:_____

NAME: _____
_____

CURRENT DATE: ____/____/_____

DATE OF BIRTH: ___/___/_____

☐ MALE

☐ FEMALE

Referring Physician:

_____

Contact ID: _____

Number
#1 = the most severe symptom

_ CPAP intolerance

_ Difficulty concentrating

_ Excessive daytime sleepiness

_ Fatigue

_ Forgetfulness

_ Frequent snoring

Number
#1 = the most severe symptom

_ Gasping causing waking up

_ Insomnia

_ Nighttime choking spells

_ Snoring which affects the sleep of others

_ Witnessed cessation of breathing

Other: Write In

_____ _____

_____ _____

Patient Signature: _____

Date: _____

SLEEP STUDIES

If you have had a Sleep Study, please check one of the following:

☐ Home Sleep Study ☐ Polysomnographic evaluation at a sleep disorder center

Sleep Center Name: _____

Sleep Study Date: ____/____/_____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of _____				
The evaluation showed:				
		during REM	*Supine*	*Side*
an RDI of	_	_	_	_
an AHI of	_	_	_	_
a nadir SpO_2 of _ T90 _ ODI _ (Oxygen Desaturation Index)				
Slow Wave Sleep ☐ Decreased ☐ None REM Sleep ☐ Decreased ☐ None				

Additional Questions

☐ Yes
☐ No Are you a current CPAP (Continuous Positive Air Pressure) user?

If Yes, what are the current CPAP settings: _____

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:

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

Other

_____ _____

_____ _____

Other Therapy Attempts

include:

- ☐ Dieting
- ☐ Weight loss
- ☐ Surgery (Uvuloplasty)
- ☐ Surgery (Uvulectomy)

Patient Signature: _____ Date: _____

Other Therapy Attempts

include:

- ☐ Pillar procedure
- ☐ Smoking cessation
- ☐ CPAP
- ☐ BiPAP
- ☐ Uvulectomy (but continues to have symptoms)
- ☐ Uvuloplasty (but continues to have symptoms)
- ☐ Positional therapy (side sleeping)
- ☐ Nasal strips

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No chance of dozing	**Slight** chance of dozing	**Moderate** chance of dozing	**High** chance of dozing	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	Sitting inactive in public place (e.g. a theater or 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

Fatigue Scale

During the past week:	**No <** 1 2 3 4 5 6 7 **> Yes**
I felt fatigued and had less motivation	☐☐☐☐☐☐☐
I felt fatigued and did not desire to exercise	☐☐☐☐☐☐☐
I felt fatigued often	☐☐☐☐☐☐☐
I felt fatigue that interfered with my physical functioning	☐☐☐☐☐☐☐
I felt fatigued which caused me frequent problems	☐☐☐☐☐☐☐
I felt fatigued which prevented sustained physical functioning	☐☐☐☐☐☐☐
I felt fatigued and couldn't carry out certain duties and responsibilities	☐☐☐☐☐☐☐
Fatigue was among my three most disabling symptoms	☐☐☐☐☐☐☐
Fatigue interfered with my work, family or social life	☐☐☐☐☐☐☐

Total Score: ___

Patient Signature: _____ Date: _____

Berlin Questionnaire Sleep Evaluation

1. Complete the following:

   Height: ___ ft, ___ in

   Weight: ___ lbs Age: ___

2. Do you snore?
   - ☐ yes
   - ☐ no
   - ☐ don't know

If you snore: *(Answer questions 3-6)*

3. Your snoring is?
   - ☐ slightly louder than breathing
   - ☐ as loud as talking

7. How often do you feel tired or fatigued after you 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

- [ ] 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

- [ ] 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

Patient Signature: _____ Date: _____

Berlin Questionnaire Sleep Evaluation

Scoring Questions: Any answer within a box 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 *(BMI = Body Mass Index)*
- [ ] Category 3 is positive with a positive response to question 10 and/or a BMI > 30 ___

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

Patient Signature

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:

_____ _____