Valley Sleep and TMJ
Sceville Dental Group
Professional care • Personalized solutions

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❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr. ❍ Other

First Name_____ Middle Initial_____ Last Name_____

Responsible Party: (If someone other than patient) Name_____

Who is primary on insurance: ❍ Self ❍ Spouse ❍ Father ❍ Mother Name_____

Date of Birth_____

Patient Information

Street Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Sex: ❍ Male ❍ Female Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

Date of Birth_____ Age_____ Social Security Number_____

Spouse Name_____ Date of Birth_____

Email_____@_____

❍ Employed Student Status: ❍ Full time ❍ Part time

Family Dentist_____ Dentist's Phone_____

Family Physician_____ Dentist's Phone_____

Referred by_____ Physician's Phone_____

MEDICAL HISTORY QUESTIONNAIRE

ALLERGENS

❑ No known allergens	❑ Iodine	❑ Plastic	❑ Antibiotics
❑ Latex	❑ Sedatives	❑ Aspirin	❑ Local Anesthetics
❑ Sleeping pills	❑ Barbituates	❑ Metals	❑ Sulfa drugs
❑ Codeine	❑ Penicillin		

Other_____

CURRENT MEDICATIONS

Medicine	Dosage/Frequency	Reason

OFFICE USE ONLY

I verify that I obtained a copy of the patient's photo ID and insurance card and made a copy of each for our records. Initial_____ Date_____

MEDICAL HISTORY (CONT'D)

Medical Condition	Never	Current	Past	Date/Note
Acid reflux	☐	☐	☐	
Anxiety	☐	☐	☐	
Anemia	☐	☐	☐	
Arthritis	☐	☐	☐	
Atherosclerosis	☐	☐	☐	
Asthma	☐	☐	☐	
Autoimmune disorder	☐	☐	☐	
Bleeding easily	☐	☐	☐	
Blood pressure – High	☐	☐	☐	
Blood pressure – Low	☐	☐	☐	
Bruising easily	☐	☐	☐	
Cancer	☐	☐	☐	
Chemotherapy	☐	☐	☐	
Chronic fatigue	☐	☐	☐	
Chronic pain	☐	☐	☐	
COPD	☐	☐	☐	
Coronary heart disease	☐	☐	☐	
Current pregnancy	☐	☐	☐	
Depression	☐	☐	☐	
Diabetes	☐	☐	☐	
Difficulty Sleeping	☐	☐	☐	
Dizziness	☐	☐	☐	
Emphysema	☐	☐	☐	
Epilepsy	☐	☐	☐	
Fibromyalgia	☐	☐	☐	
Glaucoma	☐	☐	☐	
Gout	☐	☐	☐	
Heart attack	☐	☐	☐	
Heart murmur	☐	☐	☐	
Heart pacemaker	☐	☐	☐	
Heart valve replacement	☐	☐	☐	
Hemophilia	☐	☐	☐	
_____		☐	☐	
_____		☐	☐	
_____		☐	☐	
_____		☐	☐	

Medical Condition	Never	Current	Past	Date/ Note
Hepatitis	☐	☐	☐	
Hypoglycemia	☐	☐	☐	
Immune system disorder	☐	☐	☐	
Insomnia	☐	☐	☐	
Ischemic heart disease (reduced blood supply)	☐	☐	☐	
Kidney Problems	☐	☐	☐	
Liver disease	☐	☐	☐	
Meniere's disease	☐	☐	☐	
Mitral valve prolapsed	☐	☐	☐	
Mood disorder	☐	☐	☐	
Multiple sclerosis	☐	☐	☐	
Muscular dystrophy	☐	☐	☐	
Nasal allergies	☐	☐	☐	
Neuralgia	☐	☐	☐	
Osteoarthritis	☐	☐	☐	
Osteoporosis	☐	☐	☐	
Parkinson's disease	☐	☐	☐	
Prior orthodontic treatment	☐	☐	☐	
Psychiatric care	☐	☐	☐	
Radiation treatment	☐	☐	☐	
Rheumatic fever	☐	☐	☐	
Rheumatoid arthritis	☐	☐	☐	
Sinus problems	☐	☐	☐	
Sleep apnea	☐	☐	☐	
Stroke	☐	☐	☐	
Tendency for ear infections	☐	☐	☐	
Thyroid disorder	☐	☐	☐	
Tuberculosis	☐	☐	☐	
Tumors	☐	☐	☐	
Urinary disorder	☐	☐	☐	
Wisdom teeth extraction	☐	☐	☐	
_____		☐	☐	
_____		☐	☐	
_____		☐	☐	
_____		☐	☐	

SURGICAL OPERATIONS

☐ Adenoids ☐ Heart ☐ Neck ☐ Appendectomy ☐ Hernia repair
☐ Periodontal ☐ Back ☐ Jaw joint ☐ Thyroid ☐ Ear
☐ Lung ☐ Tonsillectomy ☐ Gallbladder ☐ Nasal ☐ Uvulectomy (UPPP)

Other _____

FAMILY HISTORY

Has any member of your family (parent, sibling, or grandparent) had:

☐ Cancer ☐ Stroke ☐ Father snores ☐ Heart disease ☐ Sleep disorder
☐ Mother snores ☐ Diabetes ☐ Obesity ☐ Father has sleep apnea ☐ High blood pressure
☐ Thyroid disorder ☐ Mother has sleep apnea

Other _____

SOCIAL HISTORY

Patient's Occupation _____ Employer _____

Tobacco Use: Cigarettes: ○ Never Smoked ○ Current Smoker ○ Quit
# of pack per day _____ When did you quit?
# of years _____ _____

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use: Do you drink alcohol? ○ Yes ○ No If yes, # of drinks per week: _____

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

Regular exercise: ○ Yes ○ No

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

Please <u>number</u> the complaints with #1 being the most important.

____ Frequent heavy snoring
____ which affects the sleep of others
____ Significant daytime drowsiness
____ I have been told that "I stop breathing" when sleeping.
____ Difficulty falling asleep
____ Gasping when waking up
____ Nighttime choking spells
____ Feeling unrefreshed in the morning

____ Morning hoarseness
____ Morning headaches
____ Swelling in ankles or feet
____ Nocturnal teeth grinding
____ Jaw pain
____ Facial pain
____ Jaw clicking

Other: _____ _____

NAME: _____ DATE: _____

EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	0	1	2	3
Sitting and reading				
Watching TV				
Sitting inactive in a public place (theatre, 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 lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				

Total: _____

Screening Tool for Sleep Apnea - Developed by David White, M.D., Harvard Medical School, Boston, MA

1. Snoring

a). Do you snore on most nights (> 3 nights per week)?

Yes (2) No (0) _____

b). Is your snoring loud? Can it be heard through a door or wall?

Yes (2) No (0) _____

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0) Occasionally (3) Frequently (5) _____

3. What is your collar size?

Male: Less than 17 inches (0) more than 17 inches (5) _____

Female: Less than 16 inches (0) more than 16 inches (5) _____

4. Do you occasionally fall asleep during the day when:

a). You are busy or active?

Yes (2) No (0) _____

b). You are driving or stopped at a light?

Yes (2) No (0) _____

5) Have you had or are you being treated for high blood pressure?

Yes (1) No (0) _____

Total: _____

Score: **9 points or more** – refer to sleep specialist or order sleep study
6-8 points – gray area use clinical judgement
5 points or less – low probability of sleep apnea

Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center? ☐ Yes ☐ No

If Yes:

Sleep Center Name and Location _____

_____

Sleep Study Date _____

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The evalution confirmed a diagnosis of: ☐ *mild* ☐ *moderate* ☐ *severe* obstructive sleep apnea

The evaluation showed an RDI of _____ and an AHI of _____

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:

I could not tolerate the CPAP device due to:

- ☐ mask leaks
- ☐ I was unable to get the mask to fit properly
- ☐ discomfort caused by the straps and headgear
- ☐ disturbed or interrupted sleep caused by the presence of the device
- ☐ noise from the device disturbing my sleep and/or bed partner's sleep
- ☐ CPAP restricted movements during sleep
- ☐ CPAP does not seem to be effective
- ☐ pressure on the upper lip causing tooth related problems
- ☐ a latex allergy
- ☐ claustrophobic associations
- ☐ an unconscious need to remove the CPAP apparatus at night

Other: _____ _____

Other Therapy Attempts

What other therapies have you had for breathing disorders?
(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

_____

_____

_____

Patient Signature _____ Date _____

Berlin Questionnaire Sleep Evaluation

1. Complete the following:

height _____ age _____

weight _____ male/female _____

category 1

2. Do you snore?

- ☐ yes
- ☐ no
- ☐ don't know

If you snore:

3. Your snoring is?

- ☐ slighly 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

category 2

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

category 3

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.

Patient Signature _____ Date _____