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Version: SLPQV2

Sleep Consultation

OFFICE USE
Patient ID: _____

NAME: _____ CURRENT DATE: __/__/____
First *Middle Initial* *Last*

DATE OF BIRTH: _____ ☐MALE ☐FEMALE

Referring Physician: _____

Number
#1 = the most severe symptom

____ CPAP intolerance
____ Difficulty falling asleep
____ Fatigue
____ Frequent heavy snoring
____ Frequent heavy snoring which affects the sleep of others

____ _____
____ _____
____ _____

Continued...

____ Gasping when waking up
____ Nighttime choking spells
____ Significant daytime drowsiness
____ Sleepiness while driving
____ Witnessed apneic events

____ _____
____ _____
____ _____

Patient Signature _____ Date _____

THE EPWORTH SLEEPINESS SCALE

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

✓ 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	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (i.e. 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 quitely after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopping for a few minutes in traffic	☐	☐	☐	☐

Total Score: _____ *(Add columns 0-3)*

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

The evaluation showed

[ ] CPAP intolerance
[ ] Difficulty falling asleep
[ ] Fatigue
[ ] Frequent heavy snoring
[ ] Frequent heavy snoring which affects the sleep of others
[ ] Gasping when waking up
[ ] Nighttime choking spells
[ ] Significant daytime drowsiness
[ ] Sleepiness while driving
[ ] Witnessed apneic events
[ ] moderate obstructive sleep apnea
[ ] severe obstructive sleep apnea
[ ] mild obstructive sleep apnea

		during REM	*Supine*	*Side*
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:

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

Other _____

_____

SLEEP HISTORY

Previous Diagnosis

☐ Yes ☐ No Have you been previously diagnosed with Obstructive Sleep Apnea?

If Yes, how long ago was it? _____ ☐ Years ago ☐ Months ago ☐ Days ago
number

Sleep:

Sleep Onset Latency ____ minutes

Normally goes to bed at ___ ☐ AM ☐ PM

Hours of sleep per night ___ hours

Sleep aid ☐ Yes ☐ No

If yes, name that medication _____

__Yes __No Bruxism
__Yes __No Dry mouth
__Yes __No Excessive movements
__Yes __No Gasping
_____ Getting up <number of times> per night
__Yes __No Restless legs
__Yes __No Waking up and having difficulty returning to sleep
__Yes __No Dreaming
_____ Frequency of nocturnal urination (# of times)

Witnessed apneas are:

__Yes __No Worse during supine sleep
__Yes __No Worse following alcohol late at night

Wake

Sleepiness while driving ☐ Yes ☐ No

└ Risks discussed ☐ Yes ☐ No

The patient:

__Yes __No Awakens unrefreshed
__Yes __No Has morning headaches

_____ Naps
_____ (Choose ONE from below)
_____ naps daily
never naps
occasionally naps

Snoring is reported as:

_____ Frequency
_____ (Choose ONE from below)
_____ seldom
_____ never
daily
often

_____ Severity
_____ (Choose ONE from below)
_____ light
moderate
loud

__Yes __No Worse during supine sleep
__Yes __No Worse following alcohol late at night

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 _____