Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

# Sleep Questionnaire

First Name: _____ Last Name: _____ Birthdate: _____

Height: _____ Weight: _____

## Chief Complaints

- [ ] None
- [ ] CPAP Intolerance
- [ ] Difficulty concentrating
- [ ] Excessive daytime sleepiness
- [ ] Fatigue
- [ ] Forgetfulness
- [ ] Frequent snoring
- [ ] Gasping causing waking up
- [ ] Impaired thinking
- [ ] Insomnia
- [ ] Witnessed cessation of breathing
- [ ] Morning headaches
- [ ] Unrefreshing sleep
- [ ] Nighttime choking spells
- [ ] Snoring which affects the sleep of others
- [ ] Witnessed cessation of breathing

Additional Complaints:

## Sleep Medical History

- [ ] None
- [ ] Acid reflux
- [ ] Anemia
- [ ] Asthma
- [ ] Atrial Fibrillation
- [ ] Autoimmune disorder
- [ ] Bleeding easily
- [ ] Blood pressure - High
- [ ] Blood pressure - Low
- [ ] Bruising easily
- [ ] Chronic fatigue
- [ ] Chronic pain
- [ ] COPD
- [ ] Coronary heart disease
- [ ] Depression
- [ ] Difficulty sleeping
- [ ] Dizziness
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Excessive daytime sleepiness
- [ ] Fibromyalgia
- [ ] Glaucoma
- [ ] Gout
- [ ] Hay fever
- [ ] Heart attack
- [ ] Heart murmur
- [ ] Heart pacemaker
- [ ] Heart valve replacement
- [ ] Hemophilia
- [ ] High blood pressure
- [ ] Hypertension
- [ ] Hypoglycemia
- [ ] Immune system disorder
- [ ] Insomnia
- [ ] Ischemic heart disease (reduced blood supply)
- [ ] Meniere's disease
- [ ] Mitral valve prolapse
- [ ] Mood disorder
- [ ] Multiple sclerosis
- [ ] Muscular dystrophy
- [ ] Nasal allergies
- [ ] Neuralgia
- [ ] Osteoarthritis
- [ ] Osteoporosis
- [ ] Parkinson's disease
- [ ] Restless Legs Syndrome
- [ ] Rheumatic fever
- [ ] Rheumatoid arthritis
- [ ] Sinus problems
- [ ] Sleep apnea
- [ ] Stroke
- [ ] Tendency for ear infections
- [ ] Tumors
- [ ] Urinary disorders
- [ ] Weight gain

Additional Medical History:

## Surgical History

- [ ] None
- [ ] Appendectomy
- [ ] Back
- [ ] Ear
- [ ] Gallbladder
- [ ] Heart
- [ ] Hernia repair
- [ ] Lung
- [ ] Nasal
- [ ] Periodontal
- [ ] Thyroid
- [ ] Tonsillectomy

Additional Surgical History:

## Family History

- [ ] None
- [ ] Cancer
- [ ] Heart disease
- [ ] Diabetes
- [ ] High blood pressure
- [ ] Stroke
- [ ] Sleep disorder
- [ ] Obesity
- [ ] Thyroid disorder
- [ ] Father snores
- [ ] Mother snores
- [ ] Father has sleep apnea
- [ ] Mother has sleep apnea

## Social History

### Tobacco/Nicotine Use

- [ ] Never Smoked
- [ ] Current Smoker _____ Packs/Day _____ Years
- [ ] Quit Smoking Quit Date _____

- [ ] Pipe
- [ ] Cigar
- [ ] Snuff
- [ ] Chew
- [ ] Vape

### Alcohol Use

Do you drink alcohol? Yes [ ] No [ ] _____ Drinks/Week

### Caffeine Intake

- [ ] None
- [ ] Coffee/Tea/Soda _____ Cups/Day

## Epworth Sleep Questionnaire

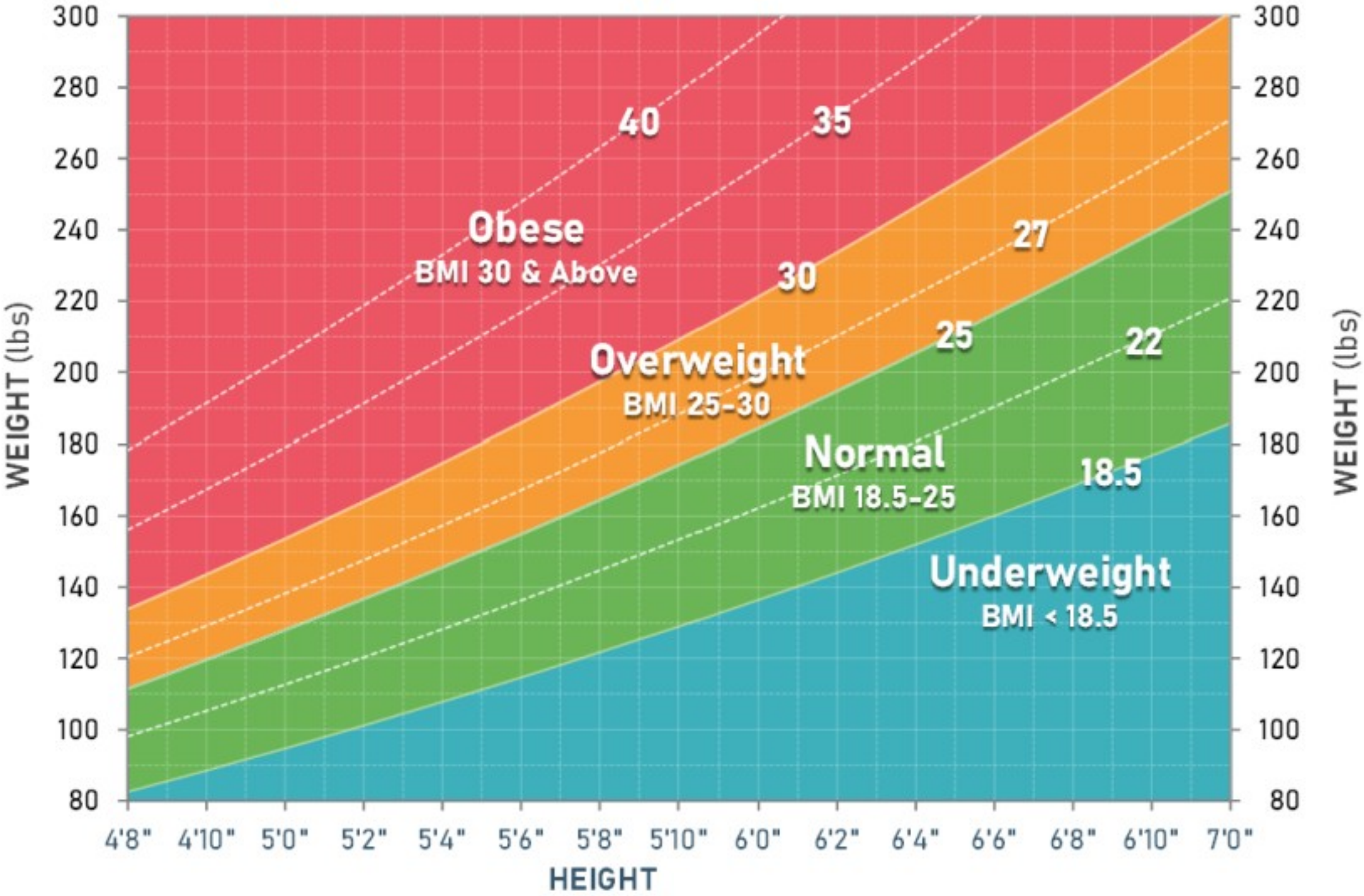
| | Never become drowsy (0) | Rarely become drowsy (1) | Frequently become drowsy (2) | Always become drowsy (3) |
|---|---|---|---|---|
| Sitting and reading | ☐ | ☐ | ☐ | ☐ |
| Watching TV | ☐ | ☐ | ☐ | ☐ |
| Sitting inactive in a public place (e.g. movie theatre) | ☐ | ☐ | ☐ | ☐ |
| As a passenger in the car for an hour without a break? | ☐ | ☐ | ☐ | ☐ |
| If you had the chance to lie down in the afternoon? | ☐ | ☐ | ☐ | ☐ |
| Sitting quietly after lunch (which did not include alcohol)? | ☐ | ☐ | ☐ | ☐ |
| While talking to someone? | ☐ | ☐ | ☐ | ☐ |
| In a car while stopped for a few minutes in traffic? | ☐ | ☐ | ☐ | ☐ |

## STOP-BANG Questionnaire

| | Yes | No |
|---|---|---|
| Do you snore loudly (louder than talking or loud enough to be heard through closed door)? | ☐ | ☐ |
| Do you often feel tired, fatigued, or sleepy during daytime? | ☐ | ☐ |
| Has anyone observed you stop breathing during your sleep? | ☐ | ☐ |
| Do you have or are you being treated for high blood pressure? | ☐ | ☐ |
| Age over 50 years old? | ☐ | ☐ |
| Neck circumference greater than 15.7 inches (40 cm)? | ☐ | ☐ |
| Is your gender male? | ☐ | ☐ |
| Body Mass Index (BMI) more than 35? | ☐ | ☐ |

Use the chart below (or an online calculator) to estimate your BMI: _____

# Body Mass Index (BMI) Chart for Adults



## Sleep History

☐ Previously diagnosed with Obstructive Sleep Apnea (OSA)? When: _____

### Snoring

Frequency: ☐ Never ☐ Seldom ☐ Often ☐ Daily

Severity: ☐ Light ☐ Moderate ☐ Loud

☐ Worse when sleeping on your back

☐ Worse following alcohol late at night

### Witnessed Apneas

☐ Worse when sleeping on your back

☐ Worse following alcohol late at night

### Sleep

How long does it take you to fall asleep? _____ minutes

Normally goes to bed at: _____ Sleep per night: _____ hours

☐ Sleep Aid? _____

☐ Racing thoughts while waiting to fall asleep?

### Patient Reports

☐ Bruxism (grinding teeth)

☐ Dry mouth

☐ Excessive movements

☐ Gasping

☐ Getting up (# of times) per night _____ times

☐ Restless legs

☐ Waking up and having difficulty returning to sleep

☐ Dreaming

☐ Vivid dreams and/or waking up feeling paralyzed

### Waking

☐ Awaken unrefreshed

☐ With morning headaches

☐ With heartburn

☐ Sleepiness while driving

☐ Sudden loss of strength in arms or legs triggered by laughter or fright?

### Naping

Frequency: ☐ Daily ☐ Occasional ☐ Never

## CPAP Intolerance

☐ None

☐ Refuses CPAP

☐ CPAP restricted movements during sleep

☐ Does not resolve symptoms

☐ Discomfort from headgear

☐ Disturbed or interrupted sleep

☐ Noise disturbing sleep and/or bed partner's sleep

☐ An unconscious need to remove the CPAP

☐ Mask leaks

☐ Pressure on the upper lip causing tooth related problems

☐ Latex allergy

☐ CPAP does not seem to be effective

☐ Inability to get the mask to fit properly

☐ Claustrophobic associations

☐ Noisy

☐ Cumbersome

## Other Therapy Attempts

- [ ] Dieting
- [ ] Weight loss
- [ ] Surgery (Uvuloplasty)
- [ ] Uvuloplasty (but continues to have symptoms)
- [ ] Surgery (Uvulectomy)
- [ ] Uvulectomy (but continues to have symptoms)
- [ ] Pillar procedure
- [ ] Smoking cessation
- [ ] CPAP
- [ ] BiPAP
- [ ] Positional therapy (side sleeping)
- [ ] Nasal strips

## Treatment History

List any treatments you have had for this problem and all health professionals that you are currently seeing. (Approximate Date, Treatment, Specialty, Practitioner's Name)

Signature

Today's Date:

If signed by a personal representative of the patient, describe the representative's relationship to and authority to act for patient.

Representative's Name: _____

Relationship: _____