Sleep Screening History Sheet

This questionnaire was designed to provide important facts regarding the history of your sleep condition. To assist in the determining the source of any problem, please take your time and answer any question as completely and honestly as possible.

PATIENT INFORMATION

Name:_______________________________________ Mrs/Mr/Miss/Ms/Dr/Prof

Address:____

Phone:_______________________Mobile:_____________________Buisness:___________________________

Sleep Specialist:____

Address:____

Phone Number:____

GP:____

Address:____

Phone:____

Family Dentist:____

Address:____

Phone:____

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

Please tick which relates to you:

____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

____Night time choking spells

____Feeling unrefreshed in the morning

___Morning hoarseness

___Morning headaches

___Swelling in ankles and feet

___Nocturnal teeth grinding

___Jaw/facial pain

___Jaw clicking

___Other

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SLEEP CENTRE EVALUATION

Have you ever had an evaluation at a Sleep Centre?: YES/NO

Sleep Centre Name & Location:___________________________

Sleep Study Date:_________________________

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

____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 THERAPY ATTEMPS

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

____

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MEDICATIONS THAT HAVE CAUSED ALLERGIC REACTIONS

____Antibiotics	____Asprin	____Barbiturates
____Codeine	____Iodine	____Latex
____Metals	____Penicillin	____Local anaesthetic
____Plastic	____Sedatives	____Sleeping Pills
____Sulphur Drugs		____Other

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS

____Antacids	____Antibiotics	____Anticoagulants
____Antidepressants	____Anti-inflammatory (non-steroid)	____Barbiturates
____Blood thinners	____Codeine	____Cortisone
____Diet pills	____Heart Medication	____High Blood Pressure
____Insulin	____Muscle relaxants	____Pain medication
____Sleeping Pills	____Sulphur Drugs	

Other current medications:____

MEDICAL HISTORY

____Anaemia	____Arteriosclerosis	____Asthma
____Autoimmune disorders	____Bleeding easily	____Chronic Sinus Problem
____Chronic Fatigue	____Congestive heart failure	____Current pregnancy
____Diabetes	____Difficulty concentrating	____Dizziness
____Emphysema	____Epilepsy	____Fibromyalgia
____Frequent sore throats	____Gastroesophageal Reflux (GERD)	____Hay fever
____Heart disorder	____Heart murmur	____Heart pounding irregularly during the night
____Heart pacemaker	____Heart valve replacement	____Heartburn
____Hepatitis	____High blood pressure	____Immune system disorder
____Insomnia	____Irregular heart beat	____Jaw joint surgery

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____Low blood pressure
____Memory loss
____Migraines
____Morning dry mouth
____Muscle spasms/cramps
____Needing extra pillows to assist breathing at night
____Night time sweating
____Osteoarthritis
____Osteoporosis
____Prior orthodontic treatment
____Poor circulation
____Recent excessive weight gain
____Rheumatic Fever
____Shortness of breath
____Swollen, stiff or painful joints
____Thyroid problems
____Tonsillectomy (have had)
____Wisdom teeth extracted

Have you had any major injuries to:

____Face ____Neck ____Head ____Mouth ____Teeth ___Back

Other relavant medical history:____

FAMILY HISTORY

Have any members of your family (blood kin) had:

____Heart Disease ____High Blood Pressure

____Diabetes

Have any immediate family members been diagnosed or treated for a sleep disorder?:

____Yes ____No

SOCIAL HISTORY

Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?

____Never ____Once a week ____Several days a week ____Daily ____Occasionally

Sedative consumption: How often do you take sedatives within 2.3 hours of bedtime?

____Never ____Once a week ____Several times a week ____Daily ____Occasionally

Caffeine consumption: How often do you consume caffeine within 2.3 hours of bedtime?

____Never ____Once a week ____Several days a week ____Daily ____Occasionally

Do you smoke? ____No ____Yes, If yes, how many per day? ____

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THE EPWORTH SLEEPINESS SCALE

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

Tick one in each row

	0 **No chance of dozing**	**1** **Slight chance of dozing**	**2** **Moderate change of dozing**	**3** **High chance of dozing**
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g.: theatre 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 minute sin traffic				

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BERLIN QUESTIONNAIRE SLEEP EVALUATION

1. Complete the following:

______Height _____Weight ____Age Male/Female

2. Do you snore?

____Yes ____No ____Don't Know

If yes, your snoring is?

____Slightly louder than breathing ____As loud as talking ____Louder than talking

____Very loud (can be heard in adjacent rooms)

3. 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 ever

4. Has your snoring ever bothered other people?

____Yes ____No

5. 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 ever

6. 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 ever

7. During your wake time, 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 ever

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8. Have you ever nodded off or fallen asleep while driving a vehicle?

____Yes ____No ____ Came very close to it

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 ever

9. Do you have high blood pressure?

____Yes ____No ____Don't Know