Sleep Issues

Patient Name _____

Date ☐☐/☐☐/☐☐☐☐

When you are asleep, the soft tissues of your throat relax, fall back and can block your airway. If there is partial blockage of your airway, these soft tissues vibrate and create Snoring. If there is total blockage of your airway with no air flow for 10 seconds or more, then there is Obstructive Sleep Apnea (OSA).

The typical sufferer tends to be a loud snorer, whose breathing is interrupted by a silent period lasting 10 seconds to a minute or more! This silence of no breathing will be repeatedly interrupted by a loud choking, gasping, and/or snorting, often hundreds of times during the night, causing severe drops in critical oxygen to your brain. The body's own natural, automatic, physiological homeostatic mechanisms react immediately to protect you as you sleep and you may not even be aware, but these defensive mechanisms can incredibly impact on your overall health, quality of life and your life itself.

Good quality sleep is critical as these repeated interruptions of no breathing with lack of oxygen can be most deadly if left untreated.

Please supply the following information:

Gender (M / F) ☐☐ Birth Date ☐☐-☐☐-☐☐☐☐

Height ☐ feet ☐ inches Weight ☐☐☐ pounds

Are you currently being treated or taking medication for:

☐ Congestive heart failure	☐ Depression	☐ Prior heart attack/Angina
☐ Hypertension/High blood pressure	☐ Irregular heartbeat	☐ Prior stroke
☐ Transient ischemic attacks	☐ Blood thinners	☐ Narcolepsy
☐ Restless leg syndrome	☐ Obstructive sleep apnea	☐ Chronic fatigue
☐ Nasal congestion/Hay fever	☐ Insomnia	☐ Oxygen therapy
☐ Acid reflux (GERD)	☐ Chronic lung disease/Asthma	☐ Frequent nightime urination
☐ Night sweats	☐ Erectile dysfunction	☐ High cholesterol

Any other please list: _____

Allergies? (Y / N) ☐☐ - ☐ Seasonal ☐ Dust ☐ Mold ☐ Pollen/Grass

Allergic to any medication? (Y / N) ☐☐ please list _____

WHITNEY FAMILY DENTISTRY

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Sleep Issues

Patient Name _____

Date ☐☐ / ☐☐ / ☐☐☐☐

Sleep Questionnaire:

Do you snore? Y ☐ N ☐ Do you have CPAP? Y ☐ N ☐
(Continuous Positive Airway Pressure)

Total Score ☐

My Snoring:

	0 NEVER	1 INFREQUENTLY	2 FREQUENTLY	3 MOST OF TIME
Is loud	☐	☐	☐	☐
Affects my relationship	☐	☐	☐	☐
Causes irritability or fatigue in myself/partner	☐	☐	☐	☐
Requires sleep in separate room	☐	☐	☐	☐
Affects other people when traveling	☐	☐	☐	☐

0-1 You are not currently experiencing symptoms for Obstructive Sleep Apnea

1-3 You have non-threatening symptoms at this time but should schedule and appointment if symptoms increase

4-5 Your health is at immediate risk. Schedule an appointment to discuss precautions

5+ You are at serious and immediate risk for Obstructive Sleep Apnea. Call today. **440.838.5550**

Spouse Questions

Please have your partner answer the following:

How likely is your spouse to doze off in the following situations?

	0 NEVER	1 INFREQUENTLY	2 FREQUENTLY	3 MOST OF TIME
Sitting or reading	☐	☐	☐	☐
Lying down to rest in the afternoon	☐	☐	☐	☐
Watching television	☐	☐	☐	☐
Sitting at talking to someone	☐	☐	☐	☐
Sitting inactive in public (ie: meeting, theater..)	☐	☐	☐	☐
Sitting quietly after lunch (no alcohol)	☐	☐	☐	☐
As a passenger in car for hour with no break	☐	☐	☐	☐
In car while stopped for traffic	☐	☐	☐	☐

Epworth Sleepiness Scale ☐

	Y / N / ?	Snoring Loudness	Partner's chief complaint
Does your bed partner snore?	☐ ☐ ☐	☐ Loud as breathing	☐ Snoring
Does their snoring bother you or others?	☐ ☐ ☐	☐ Loud as talking	☐ Sleepiness
Have they ever fallen asleep while driving?	☐ ☐ ☐	☐ Louder than talking	☐ Fatigue
Do they have high blood pressure?	☐ ☐ ☐	☐ Very loud	☐ Insomnia

	ALMOST DAILY	3-4 X PER WEEK	1-2 X PER WEEK	1-2 X PER MONTH	NEVER ALMOST NEVER
Snoring frequency	☐	☐	☐	☐	☐
Pauses in breathing	☐	☐	☐	☐	☐
Tired after sleeping	☐	☐	☐	☐	☐
Tired during wake time	☐	☐	☐	☐	☐

FOR OFFICE USE ONLY:

HYGIENIST: Score explanation _____

Answering on behalf of _____

Financial options _____

Timeline for solution _____

Health benefits _____

DENTIST: Home sleep test _____

Airway evaluation _____

Scheduling options _____