

# Great Sleep Dental

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## SLEEP SCREENING QUESTIONNAIRE

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

**PATIENT INFORMATION**

MR.    MRS.    MISS    MS.    DR.      Today's Date: \_\_\_\_\_

NAME: \_\_\_\_\_  
FIRST
MIDDLE INITIAL
LAST

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_  MALE  FEMALE

CELL PHONE: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_      AGE: \_\_\_\_\_

RESPONSIBLE PARTY: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

FAMILY DENTIST: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

Please check box if you are pregnant or think you might be, and let our office know.

|                          |                            |
|--------------------------|----------------------------|
| PRIMARY INSURANCE: _____ | SECONDARY INSURANCE: _____ |
| POLICY HOLDER: _____     | POLICY HOLDER: _____       |
| POLICY HOLDER DOB: _____ | POLICY HOLDER DOB: _____   |

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

Please number the complaints with #1 being the most important or bothersome to you.

- |   |  |
|---|--|
| <p>_____ Frequent heavy snoring</p> <p>_____ Snoring that affects the sleep of others</p> <p>_____ Sleep apnea</p> <p>_____ CPAP intolerance</p> <p>_____ Significant daytime drowsiness</p> <p>_____ Difficulty falling asleep</p> <p>_____ Gasping when waking up</p> <p>_____ Nighttime choking spells</p> <p>_____ Swelling in ankles or feet</p> | <p>_____ I have been told that "I stop breathing" when sleeping</p> <p>_____ Feeling un-refreshed in the morning</p> <p>_____ Morning hoarseness</p> <p>_____ Morning headaches</p> <p>_____ Nocturnal teeth grinding</p> <p>_____ Jaw pain</p> <p>_____ Facial pain</p> <p>_____ Jaw clicking</p> |
|---|--|

Would you be interested in a consult for Invisalign

style braces?    Yes     No

Other: \_\_\_\_\_

Office Use Only:

Temp: \_\_\_\_\_ °F

BP: \_\_\_\_\_

Pulse: \_\_\_\_\_

Height: \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Epworth Sleepiness Scale**

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How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze

2 = I have a moderate chance of dozing

1 = I have a slight chance of dozing

3 = I have a high chance of dozing

**Situation**

**Chance of Dozing**

1. Sitting and reading \_\_\_\_\_
  2. Watching TV \_\_\_\_\_
  3. Sitting inactive in a public place (e.g. a theatre or a meeting) \_\_\_\_\_
  4. As a passenger in a car for an hour without a break \_\_\_\_\_
  5. Lying down to rest in the afternoon when circumstances permit \_\_\_\_\_
  6. Sitting and talking to someone \_\_\_\_\_
  7. Sitting quietly after lunch without alcohol \_\_\_\_\_
  8. In a car while stopped for a few minutes in traffic \_\_\_\_\_
- Total Score** \_\_\_\_\_

|   | Yes                      | No                       | Not Sure                 |
|---|--------------------------|--------------------------|--------------------------|
| Have you been told (or noticed on your own) that you snore most nights?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep, sometimes followed by a GASP? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you tired, fatigued or sleepy on most days?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions)?                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you overweight?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been diagnosed with obstructive sleep apnea (OSA)?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently being treated for OSA?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you aware of family history of OSA?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you aware of clenching or grinding your teeth at night?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you snore loudly (louder than talking or loud enough to be heard behind a closed door)?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you often feel tired, fatigued or sleepy during daytime?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone observed you stop breathing during your sleep?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have or are you being treated for high blood pressure?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you 50 years old or older?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your neck measure more than 15 3/4 inches (40cm) around?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you a male?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you weigh more for your height than is shown in the table below?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Height | Weight (lb) | Height | Weight (lb) | Height | Weight (lb) | Height | Weight (lb) |
|--------|-------------|--------|-------------|--------|-------------|--------|-------------|
| 4'10"  | 167         | 5'3"   | 197         | 5'8"   | 230         | 6'1"   | 265         |
| 4'11"  | 173         | 5'4"   | 204         | 5'9"   | 237         | 6'2"   | 272         |
| 5'     | 179         | 5'5"   | 210         | 5'10"  | 243         | 6'3"   | 279         |
| 5'1"   | 185         | 5'6"   | 216         | 5'11"  | 250         | 6'4"   | 287         |
| 5'2"   | 191         | 5'7"   | 223         | 6'     | 258         | 6'5"   | 295         |

Weights shown in the tables above correspond to BMI of 35 for a given height.

**LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED YOU TO HAVE AN ALLERGIC REACTION:**

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**LIST ANY MEDICATIONS CURRENTLY BEING TAKEN (including over the counter medications, vitamins, and supplements) AND REASON FOR TAKING THE MEDICATION:**

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**MEDICAL HISTORY**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Adenoids removed         | <input type="checkbox"/> <input type="checkbox"/> Emphysema                                 | <input type="checkbox"/> <input type="checkbox"/> Hay fever   |
| <input type="checkbox"/> <input type="checkbox"/> Tonsils removed          | <input type="checkbox"/> <input type="checkbox"/> Epilepsy                                  | <input type="checkbox"/> <input type="checkbox"/> Heart disorder  |
| <input type="checkbox"/> <input type="checkbox"/> Anemia                   | <input type="checkbox"/> <input type="checkbox"/> Fibromyalgia                              | <input type="checkbox"/> <input type="checkbox"/> Heart murmur  |
| <input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis         | <input type="checkbox"/> <input type="checkbox"/> Frequent cough                            | <input type="checkbox"/> <input type="checkbox"/> Heart pounding or beating<br>Irregularly during the night |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                   | <input type="checkbox"/> <input type="checkbox"/> Frequent sore throat                      | <input type="checkbox"/> <input type="checkbox"/> Heart pacemaker   |
| <input type="checkbox"/> <input type="checkbox"/> Autoimmune disorders     | <input type="checkbox"/> <input type="checkbox"/> Gastroesophageal Reflux<br>Disease (GERD) | <input type="checkbox"/> <input type="checkbox"/> Heart palpitations  |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding easily          |   | <input type="checkbox"/> <input type="checkbox"/> Heart valve replacement                                   |
| <input type="checkbox"/> <input type="checkbox"/> Chronic sinus problems   |   | <input type="checkbox"/> <input type="checkbox"/> Heartburn or a sour taste in the<br>mouth at night        |
| <input type="checkbox"/> <input type="checkbox"/> Chronic fatigue          |   | <input type="checkbox"/> <input type="checkbox"/> Hepatitis   |
| <input type="checkbox"/> <input type="checkbox"/> Congestive heart failure |   | <input type="checkbox"/> <input type="checkbox"/> High blood pressure                                       |
| <input type="checkbox"/> <input type="checkbox"/> Current pregnancy        |   | <input type="checkbox"/> <input type="checkbox"/> Immune system disorder                                    |
| <input type="checkbox"/> <input type="checkbox"/> Depression               |   | <input type="checkbox"/> <input type="checkbox"/> Injury to face  |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes                 |   | <input type="checkbox"/> <input type="checkbox"/> Injury to mouth   |
| <input type="checkbox"/> <input type="checkbox"/> Difficulty concentrating |   |   |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness                |   |   |

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Injury to neck       | <input type="checkbox"/> <input type="checkbox"/> Morning dry mouth                                | <input type="checkbox"/> <input type="checkbox"/> Prior orthodontic treatment       |
| <input type="checkbox"/> <input type="checkbox"/> Injury to teeth      | <input type="checkbox"/> <input type="checkbox"/> Muscle spasms or cramps                          | <input type="checkbox"/> <input type="checkbox"/> Recent excessive weight gain      |
| <input type="checkbox"/> <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> <input type="checkbox"/> Muscular dystrophy                               | <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever                   |
| <input type="checkbox"/> <input type="checkbox"/> Jaw joint surgery    | <input type="checkbox"/> <input type="checkbox"/> Needing extra pillows to help breathing at night | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid arthritis              |
| <input type="checkbox"/> <input type="checkbox"/> Low blood pressure   | <input type="checkbox"/> <input type="checkbox"/> Nervous system irritability                      | <input type="checkbox"/> <input type="checkbox"/> Shortness of breath               |
| <input type="checkbox"/> <input type="checkbox"/> Memory loss          | <input type="checkbox"/> <input type="checkbox"/> Nighttime sweating                               | <input type="checkbox"/> <input type="checkbox"/> Swollen, stiff, or painful joints |
| <input type="checkbox"/> <input type="checkbox"/> Migraines            | <input type="checkbox"/> <input type="checkbox"/> Osteoarthritis                                   | <input type="checkbox"/> <input type="checkbox"/> TMJ disorder                      |
|  | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis                                     | <input type="checkbox"/> <input type="checkbox"/> Thyroid problems                  |
|  | <input type="checkbox"/> <input type="checkbox"/> Poor circulation                                 | <input type="checkbox"/> <input type="checkbox"/> Wisdom teeth extraction           |
- Other medical/dental history \_\_\_\_\_
- 
- 
- 

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**FAMILY HISTORY**

Do you have a loved one that has been diagnosed with obstructive sleep apnea and is not currently being treated?

Do you have a loved one you think might have undiagnosed sleep apnea?

Have any members of your family (blood kin) had:   Heart disease  
  High blood pressure  
  Diabetes

**SLEEP CENTER EVALUATION**

Have you ever had an evaluation at a Sleep Center?

Sleep Center Name \_\_\_\_\_ Location \_\_\_\_\_ Date of Study \_\_\_\_\_

**CPAP (Continuous Positive Airway Pressure device)**

Have you used CPAP?   For how long: \_\_\_\_\_

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: (mark all that apply)

- \_\_\_\_\_ Mask leaks
- \_\_\_\_\_ I was unable to get the mask to fit properly
- \_\_\_\_\_ Discomfort caused by the strap or headgear
- \_\_\_\_\_ Disturbed or interrupted sleep caused by the presence of the device
- \_\_\_\_\_ Noise from the device disturbing my 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, smoking cessation, surgery, etc.)?

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Has any doctor recommended that you have surgery for this condition? Y  N

**SOCIAL HISTORY**

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

- Never    Once a week    Several days a week    Daily

How often do you take sedatives within 2-3 hours of bedtime?

- Never    Once a week    Several days a week    Daily

How often do you consume caffeine within 2-3 hours of bedtime?

- Never    Once a week    Several days a week    Daily

Do you smoke? Y  N    If YES, how many a day? \_\_\_\_\_

Do you use chewing tobacco? Y  N

Patient Name \_\_\_\_\_ Date \_\_\_\_\_