

# Sleep Consultation

OFFICE USE

Patient ID: \_\_\_\_\_

NAME: \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

First

Middle Initial

Last

DATE OF BIRTH: \_\_\_\_\_

 MALE     FEMALE

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

Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

### Number

#1 = the most severe symptom

#### SLEEP BREATHING COMPLAINTS

- Jaw Clicking  
 Jaw Pain  
 Morning Head Pain  
 Morning Hoarseness  
 I have been told "I have stopped breathing"

Other - Write in: \_\_\_\_\_

### Number

#1 = the most severe symptom

- Nocturnal Teeth Grinding  
 Frequent Heavy Snoring  
 Frequent Heavy Snoring Which Affects the Sleep of Others  
 Gasping when Waking Up  
 Nighttime Choking Spells  
 Significant Daytime Drowsiness

## THE EPWORTH SLEEPINESS SCALE

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

✓ 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (i.e. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopping for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score: \_\_\_\_\_ (Add columns 0-3)

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

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# FATIGUE SCALE

During the past week:

	No <<				>> Yes		
	1	2	3	4	5	6	7
I felt fatigued and had less motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued and did not desire to exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued often . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigue that interfered with my physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued which caused me frequent problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued which prevented sustained physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued and couldn't carry out certain duties and responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue was among my three most disabling symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue interfered with my work, family or social life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score: \_\_\_\_\_

# SLEEP CENTER EVALUATION

Have you ever had an evaluation at a Sleep Center?  Yes  No

Sleep Center Name \_\_\_\_\_  
and Location \_\_\_\_\_

Sleep Study Date \_\_\_\_\_

**FOR OFFICE USE ONLY**

The evaluation confirmed a diagnosis of  mild  moderate  severe obstructive sleep apnea

The evaluation showed

	during REM	Supine	Side
an RDI of _____	_____	_____	_____
an AHI of _____	_____	_____	_____

a nadir SpO2 of \_\_\_\_\_ T90 \_\_\_\_\_

Slow Wave Sleep  Decreased  None

REM Sleep  Decreased  None

Patient Signature \_\_\_\_\_

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:

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mask leaks   | <input type="checkbox"/> Yes <input type="checkbox"/> No Claustrophobic associations            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Inability to get the mask to fit properly                | <input type="checkbox"/> Yes <input type="checkbox"/> No An unconscious need to remove the CPAP |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Discomfort from headgear                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Unable to sleep well                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Disturbed or interrupted sleep                           | <input type="checkbox"/> Yes <input type="checkbox"/> No Does not resolve symptoms              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Noise disturbing sleep and/or bed partner's sleep        | <input type="checkbox"/> Yes <input type="checkbox"/> No Noisy                                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No CPAP restricted movements during sleep                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Cumbersome                             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No CPAP does not seem to be effective                       |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pressure on the upper lip causing tooth related problems |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Latex allergy  |   |

Other \_\_\_\_\_

## OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders?

- |  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Dieting               | <input type="checkbox"/> Yes <input type="checkbox"/> No BiPap   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss           | <input type="checkbox"/> Yes <input type="checkbox"/> No Uvulectomy (but continues to have symptoms)   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Surgery (Uvuloplasty) | <input type="checkbox"/> Yes <input type="checkbox"/> No Uvuloplasty (but continues to have symptoms)  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Surgery (Uvulectomy)  | _____ Custom Item:<br>(Choose ONE from below)  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pillar procedure      | _____ Custom Item:<br>(Choose ONE from below)  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Smoking cessation     | _____ dieting failed   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No CPAP                  | <input type="checkbox"/> Yes <input type="checkbox"/> No The patient will consider oral appliance therapy and will call to schedule an appointment to proceed if he wishes to pursue treatment |

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*

## 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

## Witnessed apneas are:

\_\_Yes \_\_No Worse during supine sleep

\_\_Yes \_\_No Worse following alcohol late at night

## Sleep:

\_\_Yes \_\_No Bruxism

\_\_Yes \_\_No Cataplexy

\_\_Yes \_\_No Dry mouth

\_\_Yes \_\_No Excessive movements

\_\_Yes \_\_No Gasping

\_\_\_\_\_ Getting up <number of times> per night

\_\_Yes \_\_No Hypnagogic Hallucinations

\_\_Yes \_\_No Reading or watching TV before sleeping

\_\_Yes \_\_No Restless legs

\_\_Yes \_\_No Waking up and having difficulty returning to sleep

\_\_Yes \_\_No Dreaming

\_\_Yes \_\_No Parasomnias

\_\_\_\_\_ Frequency of nocturnal urination (# of times)

## Wake

\_\_Yes \_\_No Awakens unrefreshed

\_\_Yes \_\_No Has morning headaches

\_\_Yes \_\_No Has problematic daytime sleepiness

\_\_\_\_\_ Naps

\_\_\_\_\_ (Choose ONE from below)

\_\_\_\_\_ naps daily

\_\_\_\_\_ never naps

\_\_\_\_\_ occasionally naps

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_