bettersleepdental.ca

Dear Patient,

The following questionnaire has many questions related to sleep and other aspects of your health that may have an impact on your sleep. Please complete this form to the best of your abilities. The aim of this questionnaire is to be as thorough as reasonable to assess our ability to provide proper care for your sleep health, and we need your help in order to achieve this.

If you don't see the point of some questions, please feel free to ask the dentist at the time of your consultation. Thank you for your help.

Dr. Don Farquhar

Personal Information

Name _____ Today's date _____

Your address _____

e-mail _____ Phone ( )_____

Occupation _____ Date of Birth _____

_____ Age _____

Referred by _____ Address (city) _____

Physician _____ Address (city) _____

Dentist _____ Address (city) _____

Specialist _____ Address (city) _____

*Please **rate from 1 to 3**, in order of importance to you, the top three reasons you are here today.*

Snoring bothering bed-partner _____

Snoring bothering you _____

Daytime sleepiness or fatigue _____

Don't want to wear CPAP _____

Cannot tolerate CPAP _____

Problems with sleep _____ explain _____

Other _____

Medical History

Do you have any of the following problems? (CHECK ALL THAT APPLY)

☐ Allergies	☐ COPD	☐ Heart disease	☐ PTSD
☐ Angina	☐ Depression	☐ High blood pressure	☐ Seizure disorder
☐ Anxiety	☐ Diabetes	☐ Kidney or liver disease	☐ Sinusitis or Rhinitis
☐ Arthritis	☐ Emphysema	☐ Leg cramps while asleep	☐ Stroke or CVA
☐ Back problems	☐ Eye Disease	☐ Migraine headaches	☐ Thyroid disease
☐ Bypass surgery	☐ Fibromyalgia syndrome	☐ Morning headaches	☐ Visual disturbance
☐ Chronic fatigue syndrome	☐ GERD	☐ Neurological disease	☐ Other (list below) *
☐ Sensitivity to metals	☐ Heartburn (reflux)	☐ Post-nasal drip	

*Other _____

Your height is _____ ft. _____ in. Your weight is _____ pounds BMI | Office use |

Please list all the medications that you take and the doses, prescription and over the counter.

_____ _____

_____ _____

_____ _____

Are you allergic to any medications? ☐Yes ☐No

If yes, please list: _____

On average, how much alcohol do you drink per week?

_____ Beer _____ Glasses of wine _____ Ounces of liquor

On average how much caffeine do you take in each day?

_____ Cups of coffee _____ Cups of tea _____ Cans of cola

Do you presently smoke? ☐Yes ☐No If yes, how many cigarettes a day on average? _____

Have you smoked in the past? ☐Yes ☐No If yes, how long ago did you quit? _____

Sleep History

Have you ever had a sleep study? ☐Yes ☐No
If yes, when was it done? Date: _____ Where? _____
Have you tried CPAP? ☐Yes ☐No
Do you use CPAP now? ☐Yes ☐No How long have you used it? _____ years.
Have you tried other treatments? Describe. _____

Office use			
PSG with patient	☐Yes ☐No	Diagnostic ☐	Titration ☐
Study date		AHI	
Provider		RDI	
CPAP tried	☐Yes ☐No	H2O cm.	
SaO2 nadir			
Phase related	☐Yes ☐No	Positional	☐Yes ☐No

Do you have **non-restorative sleep**? (feeling not rested/ refreshed/ restored in the morning in spite of getting adequate amount of sleep) ☐Yes ☐No If yes, how many times per month? ____ **/30**

Do you have **trouble falling asleep**? ☐Yes ☐No If yes, how many times per month? ____ **/30**

Do you have **trouble staying asleep**? ☐Yes ☐No If yes, how many times per month? ____ **/30**

For each of the following statements, please choose the response that best describes your sleep over the past month:

I have had **difficulties getting up** in the morning.
☐ Never ☐Rarely ☐Sometimes ☐Often

I wake up **not feeling rested**.
☐Never ☐Rarely ☐Sometimes ☐Often

I have felt **as if I have not slept long enough**, even after having enough time in bed.
☐Never ☐Rarely ☐Sometimes ☐Often

I feel **refreshed after sleep**.
☐Never ☐Rarely ☐Sometimes ☐Often

What is your usual bedtime? _____
What time do you usually get up? _____
How many times per night do you get out of bed? _____
How many times do you need to use the bathroom each night? _____

Office use	
Total	

Sleep History (Continued)

Please check all that apply. **Please try to be thorough and complete** in order to help provide a clear picture of you sleep history. *Check the box if this describes **half the time or more***

☐	You have trouble falling asleep		☐	You sleep alone
☐	You waken often at night		☐	You sleep with a bed partner
☐	You have trouble falling back to sleep		☐	You awaken with a dry throat
☐	You nap		☐	You have headaches on awakening
☐	You prefer to sleep on your back		☐	You drool while sleeping
☐	You prefer to sleep on your side		☐	You have ever awakened choking
☐	You prefer to sleep on your stomach		☐	You have ever awakened gasping
☐	You **do not** have a regular bedtime		☐	You have acid reflux at night only
☐	You use the bathroom more than once a night		☐	You have family members who have apnea
☐	You use medications to help you sleep		☐	You have had adult orthodontics
☐	Your nose is stuffy going to bed		☐	You have a history of grinding or clenching
☐	You have a history of jaw pain		☐	You have a history of gum disease
☐	You work shifts		☐	You sometimes get swollen ankles

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of dozing (0-3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. theatre of 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 minutes in the traffic.	
TOTAL	

Fatigue Severity Scale

Please circle the number between 1 and 7 which you feel best fits the following statements. This refers to your usual way of life within the last week.

During the past week, I have found that:	Completely Disagree			Neither Agree Nor Disagree			Completely Agree
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7

Office Use	
Total:	Average Total divided by 9 =

STOP BANG

Do you Snore?	☐Yes ☐No
Do you feel tired, fatigued or sleepy during the day?	☐Yes ☐No
Has anyone Observed you stop breathing in your sleep?	☐Yes ☐No
Do you have high blood pressure?	☐Yes ☐No

STOP Total

Office Use Neck size? _____ cm. BMI = _____ Kg./m^2

Office use			
B	A	N	G
BMI	Age	Neck Size	Gender
>35	>50 yr.	>40 cm. >15.7”	=Male

Stop Bang Total

BMI = 35 if…

Height	58	59	**60**	61	62	63	64	65	66	67	68	69	70	71	**72**	73	74	75	76
Weight	167	173	179	185	191	197	204	210	216	223	230	236	243	250	258	265	272	279	287

By signing this document I certify that I have provided accurate answers to the above questions to the best of my ability. I understand that providing inaccurate answers may be dangerous to my health and result in inappropriate treatment. I authorize Dr. Farquhar to perform diagnostic procedures as may be required to provide necessary treatment. I understand that information provided from, or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the services for myself is mine, and I assume responsibility for fees associated with these services.

X _____ Date: _____
(signature)

Reviewed by treating dentist _____ Date: _____

Oral examination

TMJ sounds	yes / no	Number of teeth	adequate / inadequate
TMJ history	yes / no	Oral hygiene	adequate / inadequate
Mallampati class'n	1 2 3 4	Periodontal condition	adequate / inadequate
Tongue grade	1 2 3	Dental condition	adequate / inadequate
Range of motion	adequate / inadequate	Pharyngeal width	narrow /normal
Protrusive range	mm.	Tonsil grade	1 2 3 4
Vestibular space	adequate / inadequate	Uvula size	normal / large

Summary

Office Use	Score
AHI	
BMI	
Epworth	
Fatigue Scale	
STOP BANG	

OFFICE USE ONLY

Date: _____

Assessment:

Plan:

Letters:

Body Mass Index Table

	Normal						Overweight					Obese										Extreme Obesity																
BMI	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**	**40**	**41**	**42**	**43**	**44**	**45**	**46**	**47**	**48**	**49**	**50**	**51**	**52**	**53**	**54**
Height (inches)	**Body Weight (pounds)**																																			
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443