# Ashtabula Sleep Medicine Patient Questionnaire

**EPWORTH SLEEPINESS SCALE**

| | | |
|---|---|---|
| Sitting and Reading | _____ | 0 = No chance of dozing |
| Watching TV | _____ | 1 = Slight Chance of dozing |
| Sitting inactive in public place (theater) | _____ | 2 = Moderate Chance of dozing |
| As a car passenger for an hour without a break | _____ | 3 = High Chance of dozing |
| Lying down in the afternoon to rest | _____ | |
| Sitting and talking to someone | _____ | |
| Sitting quietly after lunch without alcohol | _____ | TOTAL = _____ |
| In a car while stopped at a traffic light | _____ | |

**THORNTON SNORING SCALE**

| | | |
|---|---|---|
| | | 0 = Never |
| My snoring affects my relationship with my partner | _____ | 1 = 1 night/week |
| My snoring causes my partner to be irritable or tired | _____ | 2 = 2-3 nights/week |
| My snoring requires us to sleep in separate rooms | _____ | 3 = 4+ nights/week |
| My snoring is loud | _____ | |
| My snoring affects people when I am sleeping away from home | _____ | TOTAL = _____ |

**Please list the main reason(s) you are seeking treatment for snoring or sleep apnea**:

_____

**Do you have other complaints?**

- ☐ Frequent snoring
- ☐ Excessive Daytime Sleepiness (EDS)
- ☐ Difficulty falling asleep
- ☐ Waking up gasping / choking
- ☐ Morning headaches
- ☐ Neck or facial pain
- ☐ I have been told I stop breathing when I sleep
- ☐ Other: _____
- ☐ Difficulty maintaining sleep
- ☐ Choking while sleeping
- ☐ Feeling unrefreshed in the morning
- ☐ Memory problems
- ☐ Impotence
- ☐ Nasal problems, difficulty breathing through nose
- ☐ Irritability or mood swings

## Subjective Signs and Symptoms

**Rate your overall energy level** (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)

**Rate your sleep quality** (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)

**Have you been told you snore?** YES / NO / SOMETIMES

**Rate the sound of your snoring** (Quiet) 1 2 3 4 5 6 7 8 9 10 (Loud)

**On average, how many times per night do you wake up?** _____

**On average, how many hours of sleep do you get per night?** _____

**How often do you awaken with headaches?** NEVER / RARELY / SOMETIMES / OFTEN / EVERYDAY

**Do you have a bed partner?** YES / NO / SOMETIMES **Do you sleep in the same room?** YES / NO

**How many times per night does your bedtime partner notice you stop breathing?**

SEVERAL TIMES PER NIGHT / ONCE PER NIGHT / SEVERAL TIMES PER WEEK / OCCASIONALLY / SELDOM / NEVER

# Ashtabula Sleep Medicine Patient Questionnaire

**Have you ever had a sleep study?** YES NO
**If YES, where and when?** _____**Date:**_____

**Have you tried CPAP?** YES NO
**Are you currently using CPAP?** YES NO
**If YES, how many nights per week do you wear it?** _____/ 7 Nights
**When you wear your CPAP, how many hours per night do you wear it?** _____hours per night

**If you use or have used CPAP, what are your chief complaints about CPAP?**

- ☐ Mask leaks
- ☐ An inability to get the mask to fit properly
- ☐ Discomfort from the straps or headgear
- ☐ Decrease sleep quality or interrupted sleep from CPAP device
- ☐ Noise from the device disrupting sleep and/or bedtime partner's sleep
- ☐ CPAP restricted movement during sleep
- ☐ CPAP seems to be ineffective
- ☐ Device causes teeth or jaw problems
- ☐ A latex allergy
- ☐ Device causes claustrophobia or panic attacks
- ☐ An unconscious need to remove CPAP at night
- ☐ Caused GI / stomach / intestinal problems
- ☐ CPAP device irritated my nasal passages
- ☐ Inability to wear due to nasal problems
- ☐ Causes dry nose or dry mouth
- ☐ The device causes irritation due to air leaks
- ☐ Other:

_____
_____

**Are you currently wearing a dental device?** YES NO
**Have you previously tried a dental device?** YES NO
**If YES, was it Over the Counter (OTC)?** YES NO
**Was it fabricated by a dentist?** YES NO **If YES, who fabricated it?** _____

**If applicable, please describe your previous dental device experience:**
_____

**Have you ever had surgery for snoring or sleep apnea?** YES NO

**Please list any nose, palatal, throat, tongue, or jaw surgeries you have had.**

DATE: _____ SURGEON: _____ SURGERY: _____
DATE: _____ SURGEON: _____ SURGERY: _____
DATE: _____ SURGEON: _____ SURGERY: _____

**Please comment about any other therapy attempts (weight loss, gastric bypass, etc.) and how each impacted your snoring and apnea and sleep quality.**
_____
_____
_____

# Ashtabula Sleep Medicine Patient Questionnaire

**PRE-MEDICATION – Have you been told you should receive pre-medication before dental procedures?** YES NO
**If YES, what medication(s) and why do you require it?** _____

**ALLERGENS --** Please list everything you are allergic to (for example: aspirin, latex, penicillin, etc):

_____

**MEDICATIONS --** Please list all medications you are currently taking:

_____

**MEDICAL HISTORY –** Please list all medical diagnoses and surgeries from birth until now (for example: heart attack, high blood pressure, asthma, stroke, hip replacement, HIV, diabetes, etc):

_____
_____
_____

## Dental History

**How would you describe your dental health?** EXCELLENT GOOD FAIR POOR
**Have you ever had teeth extracted?** YES NO → **If YES, please describe**_____
**Do you wear removable partials?** YES NO
**Do you wear full dentures?** YES NO
**Have you ever worn braces (orthodontics)?** YES NO → **If YES, date completed:** _____
**Does your TMJ (jaw joint) click or pop?** YES NO → **Do you have pain in this joint?** YES NO
**Have you had TMJ (jaw joint) surgery?** YES NO
**Have you ever had gum problems?** YES NO → **If YES, have you ever had gum surgery?** YES NO
**Do you have dry mouth?** YES NO
**Have you ever had an injury to your head, face, neck, or mouth?** YES NO
**Are you planning to have dental work done in the near future?** YES NO
**Do you clench or grind your teeth?** YES NO
**If you answered YES to any question above, please briefly describe your answer here:**

_____
_____

## Family History

**Have genetic members of your family had:**
**Heart Disease?** YES NO **High Blood Pressure?** YES NO **Diabetes?** YES NO
**Have genetic members of your family been diagnosed or treated for a sleep disorder?** YES NO
**How often do you consume alcohol within 2-3 hours of bedtime?** ☐ Daily ☐ Occasionally ☐ Rarely/Never
**How often do you take sedatives within 2-3 hours of bedtime?** ☐ Daily ☐ Occasionally ☐ Rarely/Never
**How often do you consume caffeine within 2-3 hours of bedtime?** ☐ Daily ☐ Occasionally ☐ Rarely/Never
**Do you smoke?** YES NO **If YES, how many packs per day?** _____
**Do you use chewing tobacco?** YES NO **If YES, how many times per day?** _____

## PATIENT SIGNATURE

**I certify that the information I have completed on these forms is true, accurate, and complete to the best of my knowledge.**
**Patient or Guardian Signature**: _____ Date: _____