Smile On Dental Salon & Sleep Apnea Center

www.smileonchicago.com

1350 W. Belmont Ave. | Unit #1 • Chicago, IL 60657

info@smileonchicago.com

(773)525-5545

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.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Age _____

Height _____

Weight _____

Neck Size _____

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

- ☐ Frequent heavy snoring
- ☐ Significant daytime drowsiness
- ☐ Difficulty falling asleep
- ☐ Nighttime choking spells
- ☐ Morning hoarseness
- ☐ Swelling in ankles or feet
- ☐ Jaw pain
- ☐ Jaw clicking
- ☐ Other
- ☐ Frequent heavy snoring which affects the sleep of others
- ☐ I have been told that "I stop breathing" when sleeping
- ☐ Gasping when waking up
- ☐ Feeling unrefreshed in the morning
- ☐ Morning headaches
- ☐ Nocturnal teeth grinding
- ☐ Facial pain
- ☐ Follow-Up

If you selected other above, please explain:

_____

_____

Sleep Center Evaluation

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

If yes:
Sleep Center Name and Location

_____

_____

Sleep Study 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.
I could not tolerate the CPAP device due to:

- ☐ mask leaks
- ☐ discomfort caused by the straps and headgear
- ☐ noise from the device disturbing my sleep and/or bed partner's sleep
- ☐ CPAP does not seem to be effective
- ☐ a latex allergy
- ☐ an unconscious need to remove the CPAP apparatus at night
- ☐ I was unable to get the mask to fit properly
- ☐ disturbed or interrupted sleep caused by the presence of the device
- ☐ CPAP restricted movements during sleep
- ☐ pressure on the upper lip causing tooth related problems
- ☐ claustrophobic associations
- ☐ other:

If you selected other above, please explain:

_____

_____

Other Therapy Attempts

What other therapies have you had for breathing disorders? (weight loss attempts, smoking cessation for at least one month, surgeries, etc.)

_____

_____

_____

List any medications which have caused an allergic reaction:

☐ Antibiotics	☐ Asprin	☐ Barbiturates	☐ Codeine	☐ Iodine	☐ Latex	☐ Local Anesthetics
☐ Metals	☐ Penicillin	☐ Plastic	☐ Sedatives	☐ Sleeping Pills	☐ Sulfa Drugs	☐ Other

If you selected other above, please explain:

_____

_____

List any medications you are currently taking:

Medical History

- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune disorders
- ☐ Bleeding easily
- ☐ Chronic sinus problems
- ☐ Chronic fatigue
- ☐ Congestive heart failure
- ☐ Current pregnancy
- ☐ Diabetes
- ☐ Difficulty Concentrating
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Frequent sore throats
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Hay fever
- ☐ Heart disorder
- ☐ Heart murmur
- ☐ Heart pounding or beating irregularly during the night
- ☐ Heart pacemaker
- ☐ Heart valve replacement
- ☐ Heartburn or a sour taste in the mouth at night
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Immune system disorder
- ☐ Injury to face
- ☐ Injury to neck
- ☐ Injury to head
- ☐ Injury to mouth
- ☐ Injury to teeth
- ☐ Insomnia
- ☐ Irregular heart beat
- ☐ Jaw joint surgery
- ☐ Low blood pressure
- ☐ Memory loss
- ☐ Migraines
- ☐ Morning dry mouth
- ☐ Muscle spasms or cramps
- ☐ Needing extra pillows to help breathing at night
- ☐ Nighttime sweating
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Poor circulation
- ☐ Prior orthodontic treatment
- ☐ Recent excessive weight gain
- ☐ Rheumatic fever
- ☐ Shortness of breath
- ☐ Swollen, stiff or painful joints
- ☐ Thyroid problems
- ☐ Tonsillectomy (have had)
- ☐ Wisdom teeth extraction
- ☐ Other:

If you selected other above, please explain:

_____

_____

Family History

Have any of your family (blood kin) had:

Heart disease ◯ Yes ◯ No

High blood pressure ◯ Yes ◯ No

Diabetes ◯ Yes ◯ No

Have any immediate family members been diagnosed or treated for a sleep disorder? ◯ Yes ◯ No

Social History

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

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

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

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

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

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

Do you smoke? ◯ Yes ◯ No

If yes, enter the number of packs per day (or other description of quantity):

_____

_____

Do you use chewing tobacco? ◯ Yes ◯ No

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeing just tired?

This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Using 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

Sitting and Reading _____

Watching TV _____

Sitting, inactive in a public place (e.g. a theatre or 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 minutess in traffic _____

TOTAL _____

Score:

0-10 Normal Range

10-12 Borderline

12-24 Abnormal

Do you snore?

☐ Yes ☐ No ☐ Don't know

If you snore:

Your snoring is?

☐ slightly louder than breathing ☐ as loud as talking ☐ louder than talking

☐ very loud. Can be heard in adjacent rooms

How often do you snore?

☐ nearly every day ☐ 3-4 times a week ☐ 1-2 times a week ☐ never or nearly never

Has your snoring ever bothered other people? ◯ Yes ◯ No

Has anyone noticed that you quit breathing during your sleep?

☐ nearly every day ☐ 3-4 times a week ☐ 1-2 times a week ☐ 1-2 times a month ☐ never or nearly never

---

How often do you feel tired or fatigued after your sleep?

☐ nearly every day ☐ 3-4 times a week ☐ 1-2 times a week ☐ 1-2 times a month ☐ never or nearly never

During your waketime, do you feel tired, fatigued or not up to par?

☐ nearly every day ☐ 3-4 times a week ☐ 1-2 times a week ☐ 1-2 times a month ☐ never or nearly never

Have you ever nodded off or fallen asleep while driving a vehicle? ◯ Yes ◯ No

How often does it occur?

☐ nearly every day ☐ 3-4 times a week ☐ 1-2 times a week ☐ 1-2 times a month ☐ never or nearly never

---

☐ **I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of additional information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.**

Response Date: ____/____/_____

Smile On Dental Salon & Sleep Apnea Center

www.smileonchicago.com

1350 W. Belmont Ave. | Unit #1 • Chicago, IL 60657

info@smileonchicago.com

(773)525-5545

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

Primary Care Physician

Physician's Name:

_____

_____

Address:

_____

_____

Phone Number:

_____

_____

Fax Number:

_____

_____

Sleep Physician

Physician's Name:

_____

_____

Address

_____

_____

Phone Number:

_____

_____

Fax Number:

_____

_____

Response Date: ____/____/_____

Smile On Dental Salon & Sleep Apnea Center
www.smileonchicago.com
1350 W. Belmont Ave. | Unit #1 • Chicago, IL 60657
info@smileonchicago.com
(773)525-5545

Informed Consent for Oral Appliance Use For the Treatment of Sleep Disordered Breathing

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

You have been diagnosed by your physician as requiring treatment for sleep disordered breathing (snoring and/or obstructive sleep apnea). This condition may pose serious health risks since it disrupts normal sleep patterns, can reduce normal blood oxygen levels and may result in excessive daytime sleepiness, irregular heart beat, high blood pressure, heart attack or stroke.

Oral appliance therapy, for snoring/obstructive sleep apnea assists breathing by keeping the tongue and jaw in a forward position during sleep. Oral appliance therapy has effectively treated many patients. However, there are no guarantees that it will be effective for you, since everyone is different and there are many factors that influence the upper airway during sleep. It is important to recognize that even when the therapy id effective, there may be a period of time before the appliance functions maximally. During this time you may still experience the symptoms related to your sleep disordered breathing. If you are medically diagnosed as having sleep apnea, a follow-up sleep study to objectively assure effective treatment is to be obtained from your physician after the oral appliance id optimally advanced.

Published studies show that short term side effects of oral appliance use may include excessive salivation, difficulty swallowing with the appliance in place, sore jaws, sore teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth and bite changes. There are also occasional reports of the dislodgement of ill-fitting dental restorations. Most of these side effects are minor and resolve quickly on their own or with minor adjustment of the appliance. Long term complications may include bite changes that may be permanent that result from tooth movement and/or jaw joint repositioning. These complications may or may not be fully reversible once appliance therapy is discontinued. If not, additional dental intervention may be suggested in certain cases for which you will be financially responsible. As the severity of the disease may increase over time, additional advancements and/or new appliances may be required in the future.

Follow-up visits with the provider of your oral appliance are mandatory to ensure proper fit and to allow an examination of your mouth to assure a healthy condition. If unusual symptoms or discomfort occur outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated evaluated further. It is recommended to have follow-up visits once every 6 months to assure proper fit and check for any side effects.

Other accepted treatments for sleep disordered breathing include behavioral modifications, positive airway pressure and various surgeries. It is your decision to have chosen oral appliance therapy to treat your sleep disordered breathing and you are aware that it may not be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to this provider's office. Failure to treat sleep disordered breathing may increase the likelihood of significant medical complications.

I have had the opportunity to discuss the foregoing conditions and the information concerning the oral appliance. Furthermore, I give my permission for my diagnostic treatment records to be used for the purpose of research. I also accept financial responsibility for this therapy. With all of the foregoing in mind, I authorize treatment and confirm that I have received a copy of this consent form.

Signature _____ **Date** _____

Response Date: ___/___/_____