

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 _____

FOR OFFICE USE ONLY

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

The evaluation showed an RDI of _____ and an AHI of _____

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
- I was unable to get the mask to fit properly
- discomfort caused by the straps and headgear
- disturbed or interrupted sleep caused by the presence of the device
- noise from the device disturbing my sleep 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 attempts, smoking cessation for at least one month, surgeries, etc.)

Patient Signature _____

Date _____

List any medications which have caused an allergic reaction:

- | | | |
|---|--|------------------------|
| Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics | Y <input type="checkbox"/> N <input type="checkbox"/> Metals | Other allergens: _____ |
| Y <input type="checkbox"/> N <input type="checkbox"/> Aspirin | Y <input type="checkbox"/> N <input type="checkbox"/> Penicillin | _____ |
| Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates | Y <input type="checkbox"/> N <input type="checkbox"/> Plastic | _____ |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine | Y <input type="checkbox"/> N <input type="checkbox"/> Sedatives | _____ |
| Y <input type="checkbox"/> N <input type="checkbox"/> Iodine | Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills | _____ |
| Y <input type="checkbox"/> N <input type="checkbox"/> Latex | Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs | _____ |
| Y <input type="checkbox"/> N <input type="checkbox"/> Local anesthetics | | |

List any medications you are currently taking:

- | | | |
|--|--|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Antacids | Y <input type="checkbox"/> N <input type="checkbox"/> Codeine | Y <input type="checkbox"/> N <input type="checkbox"/> Pain medication |
| Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics | Y <input type="checkbox"/> N <input type="checkbox"/> Cortisone | Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills |
| Y <input type="checkbox"/> N <input type="checkbox"/> Anticoagulants | Y <input type="checkbox"/> N <input type="checkbox"/> Diet pills | Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs |
| Y <input type="checkbox"/> N <input type="checkbox"/> Antidepressants | Y <input type="checkbox"/> N <input type="checkbox"/> Heart medication | Y <input type="checkbox"/> N <input type="checkbox"/> Tranquilizers |
| Y <input type="checkbox"/> N <input type="checkbox"/> Anti-inflammatory drugs
(non-steroid) | Y <input type="checkbox"/> N <input type="checkbox"/> High blood pressure medication | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates | Y <input type="checkbox"/> N <input type="checkbox"/> Insulin | Other current medications: _____ |
| Y <input type="checkbox"/> N <input type="checkbox"/> Blood thinners | Y <input type="checkbox"/> N <input type="checkbox"/> Muscle relaxants | _____ |
| | Y <input type="checkbox"/> N <input type="checkbox"/> Nerve pills | _____ |

Medical History

- | | | |
|---|--|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Anemia | Y <input type="checkbox"/> N <input type="checkbox"/> Heart pacemaker | Y <input type="checkbox"/> N <input type="checkbox"/> Osteoarthritis |
| Y <input type="checkbox"/> N <input type="checkbox"/> Arteriosclerosis | Y <input type="checkbox"/> N <input type="checkbox"/> Heart valve replacement | Y <input type="checkbox"/> N <input type="checkbox"/> Osteoporosis |
| Y <input type="checkbox"/> N <input type="checkbox"/> Asthma | Y <input type="checkbox"/> N <input type="checkbox"/> Heartburn or a sour taste
in the mouth at night | Y <input type="checkbox"/> N <input type="checkbox"/> Poor circulation |
| Y <input type="checkbox"/> N <input type="checkbox"/> Autoimmune disorders | Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis | Y <input type="checkbox"/> N <input type="checkbox"/> Prior orthodontic treatment |
| Y <input type="checkbox"/> N <input type="checkbox"/> Bleeding easily | Y <input type="checkbox"/> N <input type="checkbox"/> High blood pressure | Y <input type="checkbox"/> N <input type="checkbox"/> Recent excessive weight
gain |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chronic sinus problems | Y <input type="checkbox"/> N <input type="checkbox"/> Immune system disorder | Y <input type="checkbox"/> N <input type="checkbox"/> Rheumatic fever |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chronic fatigue | Y <input type="checkbox"/> N <input type="checkbox"/> Injury to
<input type="checkbox"/> Face <input type="checkbox"/> Neck | Y <input type="checkbox"/> N <input type="checkbox"/> Shortness of breath |
| Y <input type="checkbox"/> N <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Head <input type="checkbox"/> Mouth <input type="checkbox"/> Teeth | Y <input type="checkbox"/> N <input type="checkbox"/> Swollen, stiff or painful
joints |
| Y <input type="checkbox"/> N <input type="checkbox"/> Current pregnancy | Y <input type="checkbox"/> N <input type="checkbox"/> Insomnia | Y <input type="checkbox"/> N <input type="checkbox"/> Thyroid problems |
| Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes | Y <input type="checkbox"/> N <input type="checkbox"/> Irregular heart beat | Y <input type="checkbox"/> N <input type="checkbox"/> Tonsillectomy (have had) |
| Y <input type="checkbox"/> N <input type="checkbox"/> Difficulty concentrating | Y <input type="checkbox"/> N <input type="checkbox"/> Jaw joint surgery | Y <input type="checkbox"/> N <input type="checkbox"/> Wisdom teeth extraction |
| Y <input type="checkbox"/> N <input type="checkbox"/> Dizziness | Y <input type="checkbox"/> N <input type="checkbox"/> Low blood pressure | Other medical history:

_____ |
| Y <input type="checkbox"/> N <input type="checkbox"/> Emphysema | Y <input type="checkbox"/> N <input type="checkbox"/> Memory loss | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Epilepsy | Y <input type="checkbox"/> N <input type="checkbox"/> Migraines | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Fibromyalgia | Y <input type="checkbox"/> N <input type="checkbox"/> Morning dry mouth | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Frequent sore throats | Y <input type="checkbox"/> N <input type="checkbox"/> Muscle spasms or
cramps | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Gastroesophageal Reflux
Disease (GERD) | Y <input type="checkbox"/> N <input type="checkbox"/> Needing extra pillows to
help breathing at night | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Hay fever | Y <input type="checkbox"/> N <input type="checkbox"/> Nighttime sweating | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Heart disorder | | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Heart murmur | | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Heart pounding or beating
irregularly during the night | | |

Patient Signature _____

Date _____

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 (e.g. 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 stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>Total Score: _____</p> <p>(Add columns 0-3)</p>
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Patient Signature _____

Date _____

Berlin Questionnaire Sleep Evaluation

1. Complete the following:

height _____ age _____

weight _____ male/female _____

2. Do you snore?

yes

no

don't know

If you snore:

3. Your snoring is?

slightly louder than breathing

as loud as talking

louder than talking

very loud. Can be heard in adjacent rooms

4. How often do you snore?

nearly every day

3-4 times a week

1-2 times a week

1-2 times a month

never or nearly never

5. Has your snoring ever bothered other people?

yes

no

6. 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

7. 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

8. 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

9. Have you ever nodded off or fallen asleep while driving a vehicle?

yes

no

If yes, 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

10. Do you have high blood pressure?

yes

no

don't know

(For office use)

Scoring Questions: Any answer within the box outline is a positive response

Scoring categories:

Category 1 is positive with 2 or more positive responses to questions 2-6

Category 2 is positive with 2 or more positive responses to questions 7-9

Category 3 is positive with 1 positive response and/or a BMI > 30

(BMI = Body Mass Index)

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

Patient Signature _____

Date _____

Berlin