

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:

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

List any medications you are currently taking:

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

Medical History

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Heartburn or a sour taste
in the mouth at night | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Autoimmune disorders | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Prior orthodontic treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Bleeding easily | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Recent excessive weight
gain |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Chronic sinus problems | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Immune system disorder | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Injury to
<input type="checkbox"/> Face <input type="checkbox"/> Neck | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Insomnia | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Swollen, stiff or painful
joints |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Current pregnancy | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Jaw joint surgery | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Tonsillectomy (have had) |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Wisdom teeth extraction |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Dizziness | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Memory loss | Other medical history: _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Migraines | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Morning dry mouth | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Muscle spasms or
cramps | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Needing extra pillows to
help breathing at night | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Gastroesophageal Reflux
Disease (GERD) | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Nighttime sweating | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Hay fever | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Heart disorder | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Heart murmur | | |
| <input type="checkbox"/> 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><i>(Add columns 0-3)</i></p>

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