Sleep Consultation

What are the chief complaints for which you are seeking treatment?

1. Please number your reasons from #1 be most severe to #10 the least severe.

____ CPAP intolerance

____ Difficulty falling asleep

____ Fatigue

____ Frequent heavy snoring

____ Frequent heavy snoring which affects the sleep of others

____ Gasping when waking up

____ Nighttime choking spells

____ Significant daytime sleepiness

____ Sleepiness while driving

____ Witnessed apneic events

Other: ____

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CPAP Intolerance

Why were you unable to use CPAP?

☐ Yes ☐ No	Mask leaks	☐ Yes ☐ No	Pressure on the upper lip causing tooth related problems
☐ Yes ☐ No	Inability to get the mask to fit properly	☐ Yes ☐ No	Latex allergy
☐ Yes ☐ No	Inability to get the mask to fit properly	☐ Yes ☐ No	Claustrophobic associations
☐ Yes ☐ No	Disturbed or interrupted sleep	☐ Yes ☐ No	An unconscious need to remove it
☐ Yes ☐ No	Noise disturbing sleep and/or bed partner's sleep	☐ Yes ☐ No	Does not resolve the symptoms
☐ Yes ☐ No	CPAP restricted movements during sleep	☐ Yes ☐ No	Noisy
☐ Yes ☐ No	CPAP does not seem to be effective	☐ Yes ☐ No	Cumbersome

Other:

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Other Therapy Attempts

☐ Yes ☐ No	Dieting	☐ Yes ☐ No	Smoking cessation
☐ Yes ☐ No	Weight loss	☐ Yes ☐ No	CPAP
☐ Yes ☐ No	Surgery (Uvuloplasty)	☐ Yes ☐ No	BiPAP
☐ Yes ☐ No	Surgery (Uvulectomy)	☐ Yes ☐ No	Uvulectomy (but continues to have symptoms)
☐ Yes ☐ No	Pillar procedure	☐ Yes ☐ No	Uvuloplasty (but continues to have symptoms)

Epworth Sleep Scale

Use the following scale to choose the most appropriate number for each situation:

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

Situation	**Chance of Dozing or Sleeping**
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic while driving	

Fatigue Scale

During the past week	No << 1	2	3	4	5	6	>>Yes 7
I felt fatigued and less motivated.	☐	☐	☐	☐	☐	☐	☐
I was fatigued and did not want to exercise.	☐	☐	☐	☐	☐	☐	☐
I felt fatigued often.	☐	☐	☐	☐	☐	☐	☐
My fatigue interfered with my physical functioning.	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which caused me frequent problems.	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which prevented sustained physical functioning.	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and could not carry out certain duties and responsibilities.	☐	☐	☐	☐	☐	☐	☐
Fatigue was among my three most disabling symptoms.	☐	☐	☐	☐	☐	☐	☐
Fatigue interfered with my work, family and social life.	☐	☐	☐	☐	☐	☐	☐

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I authorize the release of a full report of examination findings, diagnosis and treatment program to your dentist or physician. I also authorize releasing this information to my insurance company to document and process my insurance claim.

Patient Signature ___________________________________ Date __________________