

# Superior Sleep and Wellness 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	_____	
In a car while stopped at a traffic light	_____	
		TOTAL = _____

## THORNTON SNORING SCALE

My snoring affects my relationship with my partner	_____	0 = Never
My snoring causes my partner to be irritable or tired	_____	1 = 1 night/week
My snoring requires us to sleep in separate rooms	_____	2 = 2-3 nights/week
My snoring is loud	_____	3 = 4+ nights/week
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?

- |  |   |
|--|---|
| <input type="checkbox"/> Frequent snoring<br><input type="checkbox"/> Excessive Daytime Sleepiness (EDS)<br><input type="checkbox"/> Difficulty falling asleep<br><input type="checkbox"/> Waking up gasping / choking<br><input type="checkbox"/> Morning headaches<br><input type="checkbox"/> Neck or facial pain<br><input type="checkbox"/> I have been told I stop breathing when I sleep<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Difficulty maintaining sleep<br><input type="checkbox"/> Choking while sleeping<br><input type="checkbox"/> Feeling unrefreshed in the morning<br><input type="checkbox"/> Memory problems<br><input type="checkbox"/> Impotence<br><input type="checkbox"/> Nasal problems, difficulty breathing through nose<br><input type="checkbox"/> 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

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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?

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

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: \_\_\_\_\_  
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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.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**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: \_\_\_\_\_