THE OROFACIAL PAIN CENTER

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Sleep Apnea Appliance Questionnaire

1. What is the main problem that brings you to our office? _____

_____

_____

2. My energy level is: (circle one) High Low Normal

3. Have you had a sleep study? Yes No
   If yes:
   Sleep Center name _____
   and location _____

   Sleep Study Date _____

   Findings / Diagnoses _____

4. 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 _____

5. What are the chief complaints for which you are seeking treatment? Please number the complaints with #1 being the most important.

___ Frequent heavy snoring
___ Significant daytime drowsiness
___ Difficulty falling asleep
___ Gasping when waking up
___ Feeling unrefreshed in the morning
___ I have been told that "I stop breathing" when sleeping
___ Morning hoarseness
___ Morning headaches
___ Nighttime teeth grinding
___ Jaw pain
___ Nighttime choking spells

Patient: _____ Date: _____

6. Check any of the following you experience:

☐Teeth pain	☐Headache	☐Neck pain
☐Back pain	☐Ear pain	☐Ear stuffiness
☐Swelling	☐Ringing in the ears	☐Hearing loss
☐Dizziness	☐Numbness in hands or fingers	☐Facial Numbness
☐Double vision	☐Easily fatigued	☐Bite changes
☐Jaw joint noises	☐Limited mouth opening	☐Difficulty swallowing
☐Aches and pains all over body	☐Pain in the back of your head	☐Jaw locking

7. If you have or have ever had jaw joint noises, please complete the following:

   a. When did the noises begin?

   _____

   b. Have they changed over time? How?

   _____

   _____

   c. Is there pain associated with the jaw joint noises?

   _____

   _____

   d. How do you describe the sounds in your jaw joints?
   ☐Click ☐Pop ☐Grating

8. Which of the following oral habits do you have?

☐Teeth clenching	☐Teeth grinding	☐Chin cupping
☐Unusual sleep positions	☐Hold phone to shoulder	☐Nail biting
☐Play musical wind instruments	☐Gum chewing	☐Scuba diving
☐Ice chewing	☐Chewing cheeks or lips	☐Other

9. Do you have any allergies?
   a. Allergies to food Yes No
   Which foods?

   _____

   b. Allergy to environmental items Yes No
   Which items?

   _____

   c. Allergies to medications Yes No
   Which medications?

   _____

Patient: _____ Date: _____

10. Check all the following that apply to you:

☐Do not sleep well
☐Awaken frequently
☐Don't feel rested in the morning
☐Pain interferes with sleep
☐Vivid dreams
☐Restless sleeper
☐ Go to bed more tired than daily activities justify

11. Do you drink any of the following?

☐Natural coffee _____cups/day
☐Natural tea ____ cups/day
☐Cola ____ glasses/day
☐Water _____ glasses/day
☐Liquor _____oz./day
☐Beer _____cans/day
☐Other
☐Decaffeinated coffee _____ cups/day
☐Decaffeinated tea ____ cups/day
☐Fruit juice _____ glasses/day
☐Milk _____ glasses/day
☐Wine _____glasses/day

12. Do you drink any caffeine or alcohol within 2-3 hours of bedtime? Yes No

13. Do you smoke? Yes No
If yes, how much per day? _____

14. Any other information you want me to know? _____
_____
_____
_____

Patient: _____ Date: _____

Previous Treatment

Please use this additional sheet if necessary to fully describe previous treatments.

1. Please list the following concerning your main complaint:
    a. Names and types of health care providers you've seen
    b. The treatment prescribed and/or provided by those health care providers
    c. The dates of treatment

Patient: _____ Date: _____

Medication List – Past and Present

Name of Drug	Dose per day	Prescribed by whom?	Prescribed for what?

Patient: _____ Date: _____

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	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (ex. a theater 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 minutes in traffic	☐	☐	☐	☐

Total Score: _____

Patient name: _____ **Date:** _____

General Medical History

Please check the box for any condition which you have had in the past or have now.

Cardiovascular

- ☐Congestive Heart Failure
- ☐Heart Attack
- ☐Angina Pectoris or chest pain
- ☐High Blood Pressure
- ☐Heart Murmur
- ☐Mitral Valve Prolapse
- ☐Rheumatic Fever
- ☐Congenital Heart Defect
- ☐Artificial Heart Valve
- ☐Arrhythmias
- ☐Heart Pacemaker
- ☐Coronary By-Pass
- ☐Coronary Angioplasty
- ☐Heart Transplant
- ☐Aneurysm
- ☐Other Heart Problem

Hematologic

- ☐Blood Transfusion
- ☐Anemia
- ☐Hemophilia
- ☐Leukemia
- ☐Sickle Cell Anemia
- ☐Tendency to Bleed Longer than Normal

Neurologic

- ☐Vision Problems
- ☐Glaucoma
- ☐Earaches
- ☐Ringing in the ears
- ☐Hearing Loss
- ☐Severe Headaches
- ☐Fainting or Dizzy Spells
- ☐Stroke
- ☐Epilepsy, Seizures
- ☐Psychiatric Treatment
- ☐Panic Attacks
- ☐Phobias

Gastrointestinal

- ☐Stomach/Intestinal Ulcers
- ☐Colitis
- ☐Persistent Diarrhea
- ☐Persistent Constipation
- ☐IBS

Hepatic

- ☐Liver Disease
- ☐Cirrhosis
- ☐Yellow Jaundice
- ☐Hepatitis

Respiratory

- ☐Asthma
- ☐Emphysema
- ☐Chronic Bronchitis
- ☐Tuberculosis (TB)
- ☐Hay Fever
- ☐Sinus
- ☐Allergies
- ☐Breathing Difficulties

Dermal/Musculoskeletal

- ☐Allergy to latex
- ☐Skin Rash
- ☐Dark Mole (s) (recent change in appearance)
- ☐Night Sweats

Orthopedic

- ☐Osteoarthritis
- ☐Artificial Joints

Rheumatologic

- ☐Rheumatoid Arthritis
- ☐Systemic Lupus
- ☐Fibromyalgia

Endocrine

- ☐Diabetes
- ☐Thyroid Disease
- ☐Taking Cortisone or Other Steroid

Genitourinary

- ☐Urinate Frequently
- ☐Kidney, Bladder Problem
- ☐Dialysis
- ☐Kidney Transplant
- ☐Sexually transmitted Disease

Other

- ☐HIV Positive
- ☐Cancer
- ☐Radiation Therapy
- ☐Chemotherapy
- ☐Drug or alcohol addiction
- ☐Disease, Problem or Condition Not Listed
- ☐If Yes, List _____

_____

_____

_____

_____

_____

_____

_____

_____