SLEEP SCREENING QUESTIONNAIRE

This questionnaire was designed to provide important facts regarding the history of your sleep condition. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible. Please sign each page.

Patient Information

TODAY'S DATE: _____

☐ MR. ☐ MS ☐ MISS ☐ MRS. ☐ DR. NAME: _____ (FIRST) (MIDDLE INITIAL) (LAST)

AGE: _____ BIRTH DATE _____ ☐ Male ☐ Female

ADDRESS: _____

CITY/STATE/ZIP: _____

HOW LONG AT CURRENT ADDRESS? _____ (IF LESS THAN THREE YEARS, PLEASE GIVE PREVIOUS ADDRESS)

PREVIOUS ADDRESS: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

RESPONSIBLE PARTY: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____

FAMILY DENTIST: _____

ADDRESS: _____

Please list other health care practitioners seen in the last 9 months: _____

INSURANCE

MEMBER NUMBER _____

GROUP NUMBER _____

PLAN NUMBER _____

NAME OF PRIMARY CARE PHYSICIAN _____

HEIGHT: _____ feet _____ inches

WEIGHT: _____ pounds

REFERRED BY: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please number the complaints with #1 being the most important.

___ Frequent heavy snoring

___ which affects the sleep of others

___ Significant daytime drowsiness

___ I have been told that "I stop breathing" when sleeping.

___ Difficulty falling asleep

___ Gasping when waking up

___ Nighttime choking spells

___ Feeling unrefreshed in the morning

___ Morning hoarseness

___ Morning headaches

___ Swelling in ankles or feet

___ Nocturnal teeth grinding

___ Jaw pain

___ Facial pain

___ Jaw clicking

Other: _____

Patient Signature _____ Date _____

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name	
Weight	Pounds	**Age**	Years	Gender **Male** ○ **Female** ○
Height	Feet / Inches		**Neck Size**	Inches
Date of Birth	Month / Day / Year		**ID Number**	Optional

Tally ARES Risk Points

Neck Size
+2 Male ≥16.5
+2 Female≥15.0

Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
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 lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score **TOTAL** the values from all 8 questions,
If 11 or less **Score = 0**
If 12 or more **Score = 2**

Score

Frequency **0 - 1 times/week** **1 - 2 times/week** **3 - 4 times/week** **5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Assign points for each of the first three responses

Signature	Area Code / Phone Number	**Total all 6 boxes from above** **If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)**	**Point Total**

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 _____

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

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 _____

Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea

Patient Name: _____ Phone Number: _____

Address: _____ City: _____ St: ___ Zip: _____

Physician: _____ Phone Number: _____

Diagnosis: Mild / Moderate / Severe Obstructive Sleep Apnea – G47.33

Prescription: E0486 – Custom fabricated oral appliance to manage sleep apnea

The above referenced patient is intolerant to, has refused or is not a candidate for CPAP therapy and is being referred for fabrication of an FDA cleared oral appliance to treat his/her sleep apnea. As his/her treating physician, I deem this therapy to be medically necessary.

To Be Filled By:

Dr. Jason Dupree

1945 E. 70th St. Ste. F

Shreveport, La. 71105

318-797-1187

Special Instructions:

_____ _____

Physician Signature Date