



Green Mountain Dental Sleep Center Patient Questionnaire

EPWORTH SLEEPINESS SCALE

Sitting and Reading _____
 Watching TV _____
 Sitting inactive in public place (theater) _____
 As a car passenger for an hour without a break _____
 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 _____

0 = No chance of dozing
 1 = Slight Chance of dozing
 2 = Moderate Chance of dozing
 3 = High Chance of dozing

TOTAL = _____

THORNTON SNORING SCALE

My snoring affects my relationship with my partner _____
 My snoring causes my partner to be irritable or tired _____
 My snoring requires us to sleep in separate rooms _____
 My snoring is loud _____
 My snoring affects people when I am sleeping away from home _____

0 = Never
 1 = 1 night/week
 2 = 2-3 nights/week
 3 = 4+ nights/week

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

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?

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

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: _____

DATE: _____ SURGEON: _____ SURGERY: _____

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
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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: _____