(704) 266-0808
10230 Berkeley Pl Dr # 200,
Charlotte, NC 28262

Monday-Friday 9:00am-5:00pm

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	_____	TOTAL = _____
In a car while stopped at a traffic light	_____	

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?

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

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? _____ 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.
_____
_____

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 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 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: _____

Submit