Webster Dental Care

Bed Partner Questionnaire

Name of patient: _____

Your relationship to patient: _____

How often have you observed this person's sleep? ☐ Never ☐ Once or twice ☐ Often ☐ Every night

Has this person fallen asleep during normal daytime activities or in dangerous situations? If yes, explain: _____

_____

What behaviors have you observed in this person while he or she was asleep? Check all that apply:

- ☐ Light snoring
- ☐ Loud snoring
- ☐ Occasional loud snorts
- ☐ Choking
- ☐ Pauses in breathing
- ☐ Teeth grinding
- ☐ Limb movements every 10-20 seconds
- ☐ Awaking with pain
- ☐ Sleepwalking
- ☐ Leg kicking
- ☐ Shaking or rocking
- ☐ Becoming very rigid
- ☐ Sitting up in bed
- ☐ Head rocking/banging
- ☐ Bedwetting
- ☐ Doing an unusual activity
- ☐ Leg or arm twitching
- ☐ Other: _____

Please describe the checked behaviors in more detail. Include a description of the behavior, when it occurs during the night, frequency during the night, and how often it occurs (every night, 4 times a week, etc.)

_____

_____

_____

_____

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Epworth Sleepiness Scale

Name: _____

Date: _____

Your sex: ☐ Male ☐ Female Your age: _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

Situation	**Chance of dozing**
Sitting and reading……..	
Watching TV……..	
Sitting, inactive in a public place (e.g. a theatre 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 taking to someone……	
Sitting quietly after a lunch without alcohol……..	
In a car, while stopped for a few minutes in the traffic…….	
Total……..…..	

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Patient Questionnaire

Please make sure to bring this completed form to your appointment

Patient:_____ **Date of Birth:**_____

Reason for evaluation: _____

How long have you had this problem?_____

Name of Primary Care Physician: _____**Telephone#:**_____

Check any of the boxes that you have experienced in the past 6 months:

☐ Night Sweats	☐ Heat or Cold Intolerance	☐Chest Discomfort
☐ Weight Gain/ Loss	☐Coughing or Wheezing	☐Rapid Heart Beat
☐ Passing Out	☐Anxiety	☐Leg/ Feet Swelling
☐ Numbing/ Tingling	☐Muscle Aches and Cramps	☐Trouble Breathing
☐ Headache	☐Heartburn	☐Sinus Congestion
☐ Depression	☐Frequent Urination	☐Nausea or Vomiting
☐ Weak muscles when telling or hearing a joke	☐Heard or seen things that were not there (as if dreaming, but awake) when walking or falling asleep	☐Felt as if you could not move when waking or falling asleep
		☐ Allergies
☐ Back Pain	☐ Other:	☐ None

Please list all your medications, indluding over-the-counter meds and herbal remedies:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any allergies to medicine? If so, please list them:_____

_____

Do you have a history of: **(Please check all boxes that apply)**

☐ Stroke or TIA	☐ Seizures/Other Neurological Diseases	☐ High Blood Pressure	☐ Diabetes
☐ Heart Disease	☐ Drug or Alcohol Addiction	☐ Kidney Disease	☐Depression
☐ Thyroid Disease	☐ Deviated Nasal Septum	☐ Lung Disease	☐Anxiety

Past or Current Medical Problems:_____

_____

Past Surgeries:_____

_____

Have you had your tonsils removed? ☐Yes ☐No **if so, at what age?** _____

Patient Questionnaire

Occupation:_____

Do you smoke? ☐ Yes ☐ No If so, for how many years and how much? _____

Do you drink Alcohol? ☐ Yes ☐ No If so, how many drinks per week?_____

Do you drink coffee, caffeinated soda, or tea? ☐Yes ☐ No If so, how many cups per day?_____

Please mark any of the below occurrences that either you or someone else has observed of you:

☐ **Snoring**	☐ **Acting Out Dreams**	☐ **Wake Up Gasping For Air**
☐ **Leg Jerks**	☐ **Nighttime Wheezing**	☐ **Stop Breathing While Sleeping**
☐ **Restless Sleep**	☐ **Vivid Dreams/Nightmares**	☐ **Take Sleeping Medication**
☐ **Talking In Sleep**	☐ **Morning Headacheas**	☐ **Creeping/Crawling Feeling In legs**
☐ **Teeth Grinding**	☐ **Sleep Disrupting Ideas**	☐ **Feel The Need To Move Your Legs**
☐ **Sleep Walking**	☐ **Awaken With Dry Mouth**	☐ **Pain That Interferes With Sleep**
☐ **Seizures**	☐ **Dementia**	☐ **Excessive Sleepiness**
☐ **Parkinson's Disease**	☐ **Narcolepsy**	☐ **Insomnia**
☐ **Sleep Apnea**	☐ **None**	

Have you ever had a Sleep study? _____ When:_____
Location of sleep study:_____ Doctor:_____

Have you ever had an oral appliance or ventilation equipment to treat a sleep or snoring problem? _____
What type:_____

Is your nighttime sleep refreshing ☐ Yes ☐No
Are you sleepy/fatigued during the day ☐ Yes ☐No If yes, what time of day is worse?_____
If you snore, what sleeping positions do you snore in? ☐ Back ☐Side ☐ Stomach
Does your snoring disturb others? ☐Yes ☐ No
What positions do you sleep in: ☐ Back ☐ Side ☐Stomach

Mark any of the following that you do while you are in bed:
☐ Read ☐ Eat ☐ Watch TV ☐ Do work activities ☐ Sleep with the TV on

How many times do you wake to use the restroom?_____
How long does it take you to fall back to sleep? _____ If you have difficulty falling asleep, what do you do? _____
Do you take naps? ☐ Yes ☐ No If yes, how long are they? _____
Do you dream during the naps? ☐ Yes ☐ No Are the naps refreshing? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No If yes, what time of day do you exercise? _____

Patient Name:

Patient Address:

Dear_____,

Welcome to our practice. We are delighted that you have chosen us for your Oral Appliance Therapy to treat your snoring or Obstructive Sleep Apnea. Our team is highly skilled and committed to making your experience at Webster Dental Care as pleasant as possible.

Enclosed are a Snoring and Sleep Apnea Questionnaire. Please fill out the forms completely, as your accurate history and symptoms are vital to our doctors during your first visit.

Also, please:

- Have your bed partner fill out the Bed Partner Survey
- Fill out the Epworth Sleepiness Scale
- Bring all forms completed to your appointment with you.

If you have any questions, please call our sleep coordinator, Paula at (847) 673-7118.

Your initial visit is on _____. Your initial examination and consultation fee is $103.00. We appreciate the value of your time, and strive to be on time and answer any diagnosis, treatment and financial questions that you may have during your visit. If you have an emergency or unable to keep your appointment for any reason, please notify us as early as possible.

We look forward to seeing you.

Sincerely,

Webster Dental Care