Patient Questionnaire

Full Name: _____ Date of Birth: _____

Thorton Snoring Scale: Using the following numbered scale, choose the most appropriate number for each situation. **0= never, 1= slight, 2= moderate, 3 = high** (Choose one of the following numbers)		Subjective Signs/ Symptoms Using the following numbered scale, choose the most appropriate number for each situation. **0 = Lowest, 10 = Highest**	
My snoring affects my relationship with my partner		Rate your Overall Energy Level	
My snoring requires us to sleep in separate rooms		Rate your Sleep Quality	
My snoring is loud		Rate the sound of your snoring	
My snoring affects people when I am sleeping away from home		On average, how many nights do you wake up?	
		How often do you awaken with headaches?	
		Do you have a bedtime partner? If yes, do you sleep in the same room?	

Subjective Complaints

These are common complaints for folks who have sleep disordered breathing. Please circle all that apply:

Frequent Snoring	**Daytime Sleepiness**	**Difficulty *falling* Asleep**	**Difficulty *staying* asleep**
Waking up gasping or choking	**Morning Headaches**	**Neck or facial pain**	**I've been told I stop breathing when asleep**
Feeling unrefreshed in the morning	**Memory Problems**	**Impotence**	**Difficulty breathing nose**
Irritability	**Mood Swings**	**Other (describe below)**	

Other: _____

_____

_____

Have you ever had a sleep study?_____ Date of Sleep Study:_____

Location of sleep study?_____

CPAP intolerance

Have you been told that you snore?_____ **Are you currently using a CPAP?_____**

What are your chief complaints about CPAP? Please circle all that apply:

Claustrophobic feeling	**Mask leaks**	**Allergic to material**	**I take it off in my sleep**
GI/ Stomach/ Intestinal	**The air irritated my nose**	**Can't wear due to nasal issues**	**CPAP causes dry nose and/or mouth**
Device causes eye irritation due to air leak	**Mask didn't fit properly**	**Discomfort from straps or headgear**	**Sleep interrupted by CPAP**
Noise disrupts mine or my bedtime partner's sleep	**CPAP restricted movements**	**I don't think it is effective**	**Device causes teeth or jaw problems**

Other:_____

_____

_____

Dental Devices:

Are you currently wearing a dental device specifically designed to treat sleep apnea?_____

Have you previously tried a dental device for sleep apnea treatment? _____

If yes, was it over the counter? _____ Was it fabricated by a dentist? _____

Please describe what you've used to treat your snoring/sleep apnea:_____

_____

Surgery:

Have you ever had surgery for snoring or sleep apnea? _____ What type? _____

Date or year of surgery: _____ Surgeon/Location: _____

Any other surgeries: _____

Please comment about any other therapy attempts (weight loss, gastric bypass, etc.) and how each impacted your snoring and sleep quality: _____

_____

Medications:

Premedication:

☐ Have you been told you should receive pre-medication before dental procedures? _____

Allergens:

Do you have any known allergens (for example: aspirin, latex, penicillin, etc.)? _____

_____

Current medications:

Are you currently taking any medications? _____

Please list your medications:_____

_____

_____

Dental History:

How would you describe your dental health? Poor Fair Good Great

Have you ever had teeth extracted? (including wisdom) _____

Do you wear removable partials? _____ Do you wear dentures?_____

Have you worn braces? _____ Does your TMJ (jaw joint) click or pop? _____

Do you have pain in that joint? _____ Have you ever had TMJ surgery? _____

Have you ever had gum problems? _____Have you ever had gum surgery? _____

Have you ever had big injuries to your head, face, neck, mouth, or teeth? If so, please explain: _____

_____

Are you planning to have dental work done in the near future? (Within the next 2 years): _____

Do you grind or clench your teeth? _____

Family History:

Have genetic members of your family had Heart Disease? _____ High Blood Pressure? _____

Diabetes? _____ Has anyone else in your family been treated for a sleep disorder?_____

Social History: Consider the following consumables within 2-3 hours of your normal bedtime.

Alcohol:	Never	Rarely	Sometimes	Often	Everyday
Sedatives:	Never	Rarely	Sometimes	Often	Everyday
Caffeine:	Never	Rarely	Sometimes	Often	Everyday

Do you smoke cigarettes? _____ Recreational drug use, past or present? _____

Do you use chewing tobacco? _____ If yes, how many times a day? _____

Have you seen your primary care dr. within the last year? _____ Which office? _____

_____ _____

Patient Signature Date