

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

√ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature _____

Date _____

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 _____

FOR OFFICE USE ONLY

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

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 _____

List any medications which have caused an allergic reaction:

- Antibiotics
 Aspirin
 Barbiturates
 Codeine
 Iodine
 Latex
 Local anesthetics

- Metals
 Penicillin
 Plastic
 Sedatives
 Sleeping pills
 Sulfa drugs

Other allergens:

List any medications you are currently taking:

- Antacids
 Antibiotics
 Anticoagulants
 Antidepressants
 Anti-inflammatory drugs
 (non-steroid)
 Barbiturates
 Blood thinners

- Codeine
 Cortisone
 Diet pills
 Heart medication
 High blood pressure medication
 Insulin
 Muscle relaxants
 Nerve pills

- Pain medication
 Sleeping pills
 Sulfa drugs
 Tranquilizers

Other current medications:

Medical History

- Anemia
 Arteriosclerosis
 Asthma
 Autoimmune disorders
 Bleeding easily
 Chronic sinus problems
 Chronic fatigue
 Congestive heart failure
 Current pregnancy
 Diabetes
 Difficulty concentrating
 Dizziness
 Emphysema
 Epilepsy
 Fibromyalgia
 Frequent sore throats
 Gastroesophageal Reflux
 Disease (GERD)
 Hay fever
 Heart disorder
 Heart murmur
 Heart pounding or beating
 irregularly during the night

- Heart pacemaker
 Heart valve replacement
 Heartburn or a sour taste
 in the mouth at night
 Hepatitis
 High blood pressure
 Immune system disorder
 Injury to
 Face Neck
 Head Mouth Teeth
 Insomnia
 Irregular heart beat
 Jaw joint surgery
 Low blood pressure
 Memory loss
 Migraines
 Morning dry mouth
 Muscle spasms or
 cramps
 Needing extra pillows to
 help breathing at night
 Nighttime sweating

- Osteoarthritis
 Osteoporosis
 Poor circulation
 Prior orthodontic treatment
 Recent excessive weight
 gain
 Rheumatic fever
 Shortness of breath
 Swollen, stiff or painful
 joints
 Thyroid problems
 Tonsillectomy (have had)
 Wisdom teeth extraction

Other medical history:

Berlin Questionnaire Sleep Evaluation

1. Complete the following:

height _____ age _____

weight _____ male/female _____

2. Do you snore?

yes

no

don't know

If you snore:

3. Your snoring is?

slightly louder than breathing

as loud as talking

louder than talking

very loud. Can be heard in adjacent rooms

4. How often do you snore?

nearly every day

3-4 times a week

1-2 times a week

1-2 times a month

never or nearly never

5. Has your snoring ever bothered other people?

yes

no

6. Has anyone noticed that you quit breathing during your sleep?

nearly every day

3-4 times a week

1-2 times a week

1-2 times a month

never or nearly never

7. How often do you feel tired or fatigued after your sleep?

nearly every day

3-4 times a week

1-2 times a week

1-2 times a month

never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?

nearly every day

3-4 times a week

1-2 times a week

1-2 times a month

never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?

yes

no

If yes, how often does it occur?

nearly every day

3-4 times a week

1-2 times a week

1-2 times a month

never or nearly never

10. Do you have high blood pressure?

yes

no

don't know

(For office use)

Scoring Questions: Any answer within the box outline is a positive response

Scoring categories:

Category 1 is positive with 2 or more positive responses to questions 2-6

Category 2 is positive with 2 or more positive responses to questions 7-9

Category 3 is positive with 1 positive response and/or a BMI > 30

BMI =

(Body Mass Index)

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

Patient Signature _____

Date _____

Screening Tool for Sleep Apnea

Developed by David White, M.D., Harvard Medical School, Boston, MA

In whom should apnea be considered? If you suspect sleep apnea, ask your patient the following questions:

1. Snoring

a) Do you snore on most night (> 3 nights per week)?

Yes (2)

No (0)

b) Is your snoring loud? Can it be heard through a door or wall?

Yes (2)

No (0)

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0)

Occasionally (3)

Frequently (5)

3. What is your collar size?

Male: Less than 17 inches (0) more than 17 inches (5)

Female: Less than 16 inches (0) more than 16 inches (5)

4. Do you occasionally fall asleep during the day when:

a) You are busy or active?

Yes (2)

No (0)

b) You are driving or stopped at a light?

Yes (2)

No (0)

5. Have you had or are you being treated for high blood pressure?

Yes (1)

No (0)

TOTAL

Score

9 points or more

Refer to sleep specialist or order sleep study

6-8 points

Gray area, use clinical judgment

5 points or less

Low probability of sleep apnea



Center for TMJ Therapy

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Social Security Number: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Alpharetta office manager phone (770) 521 1978 fax (770) 521 9936 or 3590 Old Milton Parkway, Alpharetta, GA 30005

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCACTION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.