Dr. Bryan & Dr. Cheryl Freeman

Randolph Center for Dental Excellence

An Exceptional Approach To Your Dental Care

SLEEP APNEA PATIENT QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

Phone (home):_____ (work) _____ (cell)_____

Patient's Email: _____

Patient's Doctor: _____

Doctor's Address: _____ Phone: _____

Referring Specialist's Name: _____ Phone: _____

Medical conditions often co-morbid with obstructive sleep apnea. Ask patient if they suffer(ed) from:

Hypertension/drug resistant hypertension	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
GERD/acid reflux	☐ Yes	☐ No
Heart disease/coronary artery disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No

Snoring and sleep disordered breathing conditions. Ask the patient:

1. Do you snore or have you been told you snore?	☐ Yes	☐ No
2. Do you snore only when you are lying on your back?	☐ Yes	☐ No
3. Do you snore every night?	☐ Yes	☐ No
4. Have you been told you stop breathing or gasp during sleep?	☐ Yes	☐ No
5. Has your partner had to move to another room during the night?	☐ Yes	☐ No
6. Are you currently or have you been treated for high blood pressure?	☐ Yes	☐ No
7. Do you doze off unintentionally during the day?	☐ Yes	☐ No
8. Do you fall asleep when driving?	☐ Yes	☐ No
9. Do you often awaken feeling tired?	☐ Yes	☐ No
10. Do you often awaken with a headache?	☐ Yes	☐ No
11. Do you have problems concentrating for long periods of time?	☐ Yes	☐ No
12. Are you having accidents on the job or at home?	☐ Yes	☐ No
13. Do you feel pain in your jaw joints in the area of the ear?	☐ Yes	☐ No
14. Do you grind or clench your teeth in your sleep?	☐ Yes	☐ No
15. Do you suspect you have sleep apnea?	☐ Yes	☐ No
16. Have you ever been treated for snoring, a sleep disorder, or sleep apnea?	☐ Yes	☐ No
17. Have you ever participated in a sleep study?	☐ Yes	☐ No

- When? _____ Where? _____
- How is C-PAP working for you? _____

Family History

Have any family members had heart disease/high blood pressure/diabetes?	☐ Yes	☐ No
Do any family members snore, have sleep apnea, or a sleep disorder?	☐ Yes	☐ No

If yes, who? _____

Personal History and Anatomy

Age: _____ Weight:_____ Height: _____

Neck circumference: _____ Risk factor: Male >17" Female >15"

Alcohol consumption (number of drinks per week)_____

Are there potential obstructions to the airway?

☐enlarged tonsils ☐enlarged tongue ☐enlarged uvula ☐enlarged adenoids ☐ recessed chin

BRING DENTAL/MEDICAL INSURANCE CARD(S) TO APPOINTMENT