



# 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:

---



---



---



---

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



# THE EPWORTH SLEEPINESS SCALE

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

| √ Check one in each row:   | 0<br>No chance<br>of dozing | 1<br>Slight chance<br>of dozing | 2<br>Moderate<br>chance of<br>dozing | 3<br>High chance<br>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"/>      |

|  |
|--|
| <p>Total Score: _____</p> <p>(Add columns 0-3)</p> |
|--|

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

# 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

(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.

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

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Berlin