Dental Crafters, Inc.

# Significant Other Form

**Questionnaire for Sleep Apnea and/or Snoring**

Your Name: _____

Partners Name: _____

Today's Date: _____

1. How long have you been aware of your partner's snoring? _____(number of years)

2. Has it caused problems for you or friends? ☐ Yes ☐ No

3. Have you noticed that your partner's breathing stops while asleep? ☐ Yes ☐ No

4. Have you noticed your partner move around a lot while asleep? ☐ Yes ☐ No

5. About how many times per night does your partner wake up? ☐ 1–4 ☐ 5–9 ☐ 10 or more

6. Does your partner have any difficulty falling asleep at night? ☐ Yes ☐ No

7. How many hours of sleep per night does your partner get? _____(hours of sleep)

8. Does your partner most often wake up feeling refreshed? ☐ Yes ☐ No

9. Does your partner often wake up with a headache? ☐ Yes ☐ No

10. Will a small amount of alcohol give your partner a hangover? ☐ Yes ☐ No

11. Does your partner feel sleepy during the day? ☐Frequently ☐Occasionally ☐Seldom ☐Never ☐Uncertain

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# Sleep Solutions: Three Easy Steps

## Initial Evaluation Forms

- Initial Patient Evalution Form
- Epworth Sleepiness Scale
- Significant Other Form

Talk with your patients about their sleeping habits. If you believe they may be suffering from a sleep disorder, complete the following forms with the help of your patient and their significant other.

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# Initial Patient Evaluation Form

## Initial Evaluation Questionnaire

Name: _____

Date: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Age: _____

Family Physician: _____

Is there usually a bed partner to observe your sleep? ☐ Yes ☐ No

| During the last week: | Never | Rarely | Sometimes | Often |
|---|---|---|---|---|
| 1. Have you snored or have you been told that you do? | ☐ | ☐ | ☐ | ☐ |
| 2. Have you had choking or shortness of breath sensations at night? | ☐ | ☐ | ☐ | ☐ |
| 3. Have you woken up during sleep? | ☐ | ☐ | ☐ | ☐ |
| 4. Have you had morning fatigue or fogginess or woken up feeling unrefreshed? | ☐ | ☐ | ☐ | ☐ |
| 5. Have you woken up with a headache? | ☐ | ☐ | ☐ | ☐ |
| 6. Have you had chronic sleepiness, fatigue or weariness that you can't explain? | ☐ | ☐ | ☐ | ☐ |
| 7. Have you fallen asleep during the day, particularly when not busy? | ☐ | ☐ | ☐ | ☐ |
| 8. Have you fallen asleep reading or watching television? | ☐ | ☐ | ☐ | ☐ |
| 9. Have you fallen asleep during the day against your will? | ☐ | ☐ | ☐ | ☐ |
| 10. Have you had to pull off the road while driving due to sleepiness? | ☐ | ☐ | ☐ | ☐ |
| 11. Have you been more irritable and short-tempered? | ☐ | ☐ | ☐ | ☐ |
| 12. Have you felt your working habits and/or intellect is impaired? | ☐ | ☐ | ☐ | ☐ |
| 13. Have you been told that you stop breathing while asleep? | ☐ | ☐ | ☐ | ☐ |

14. Do you have difficulty breathing through your nose? _____

15. Have you gained weight recently? _____ If so, approximately how much? _____

16. Present body weight: _____ Height: _____

17. What other doctors have you seen about your snoring or sleep apnea? _____

18. Have you had a sleep lab study? ☐ Yes ☐ No Date of study? _____

19. What professional advice or treatment have you received about your snoring or sleep apnea?

_____

_____

20. Have you attemted treatment with C.P.A.P. device? ☐ Yes ☐ No

21. Do you use C.P.A.P.? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

## The Epworth Sleepiness Scale

*(Patient to complete)*

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

| Check one in each row | 0 would never doze | 1 slight chance of dozing | 2 moderate chance of dozing | 3 high chance of dozing |
|---|---|---|---|---|
| Sitting and reading | ☐ | ☐ | ☐ | ☐ |
| Watching TV | ☐ | ☐ | ☐ | ☐ |
| Sitting, inactive in a public place (e.g. theater or 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 talking to someone | ☐ | ☐ | ☐ | ☐ |
| Sitting quietly after lunch without alcohol | ☐ | ☐ | ☐ | ☐ |
| In a car, while stopped for a few minutes in the traffic | ☐ | ☐ | ☐ | ☐ |

Total Score: _____
(Add columns 0-3)

Patient Signature: _____ Date: _____