

# Webster Dental Care

## Bed Partner Questionnaire

Name of patient: \_\_\_\_\_

Your relationship to patient: \_\_\_\_\_

How often have you observed this person's sleep?    Never    Once or twice    Often    Every night

Has this person fallen asleep during normal daytime activities or in dangerous situations? If yes, explain: \_\_\_\_\_

What behaviors have you observed in this person while he or she was asleep? Check all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> Light snoring                      | <input type="checkbox"/> Leg kicking               |
| <input type="checkbox"/> Loud snoring                       | <input type="checkbox"/> Shaking or rocking        |
| <input type="checkbox"/> Occasional loud snorts             | <input type="checkbox"/> Becoming very rigid       |
| <input type="checkbox"/> Choking                            | <input type="checkbox"/> Sitting up in bed         |
| <input type="checkbox"/> Pauses in breathing                | <input type="checkbox"/> Head rocking/banging      |
| <input type="checkbox"/> Teeth grinding                     | <input type="checkbox"/> Bedwetting                |
| <input type="checkbox"/> Limb movements every 10-20 seconds | <input type="checkbox"/> Doing an unusual activity |
| <input type="checkbox"/> Awakening with pain                | <input type="checkbox"/> Leg or arm twitching      |
| <input type="checkbox"/> Sleepwalking                       | <input type="checkbox"/> Other: _____              |

Please describe the checked behaviors in more detail. Include a description of the behavior, when it occurs during the night, frequency during the night, and how often it occurs (every night, 4 times a week, etc.)

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# Webster Dental Care

## Epworth Sleepiness Scale

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Your sex:       Male       Female      Your age: \_\_\_\_\_

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

- 0 = would NEVER doze
- 1 = SLIGHT chance of dozing
- 2 = MODERATE chance of dozing
- 3 = HIGH chance of dozing

<b>Situation</b>	<b>Chance of dozing</b>
Sitting and reading.....	<input type="text"/>
Watching TV.....	<input type="text"/>
Sitting, inactive in a public place (e.g. a theatre or a meeting).....	<input type="text"/>
As a passenger in a car for an hour without a break.....	<input type="text"/>
Lying down to rest in the afternoon when circumstances permit.....	<input type="text"/>
Sitting and talking to someone.....	<input type="text"/>
Sitting quietly after a lunch without alcohol.....	<input type="text"/>
In a car, while stopped for a few minutes in the traffic.....	<input type="text"/>
<b>Total</b> .....	<input type="text"/>

# Webster Dental Care Patient Questionnaire

Please make sure to bring this completed form to your appointment

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for evaluation: \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Check any of the boxes that you have experienced in the past 6 months:

<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Heat or Cold Intolerance	<input type="checkbox"/> Chest Discomfort
<input type="checkbox"/> Weight Gain/ Loss	<input type="checkbox"/> Coughing or Wheezing	<input type="checkbox"/> Rapid Heart Beat
<input type="checkbox"/> Passing Out	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Leg/ Feet Swelling
<input type="checkbox"/> Numbing/ Tingling	<input type="checkbox"/> Muscle Aches and Cramps	<input type="checkbox"/> Trouble Breathing
<input type="checkbox"/> Headache	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Sinus Congestion
<input type="checkbox"/> Depression	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Nausea or Vomiting
<input type="checkbox"/> Weak muscles when telling or hearing a joke	<input type="checkbox"/> Heard or seen things that were not there (as if dreaming, but awake) when walking or falling asleep	<input type="checkbox"/> Felt as if you could not move when waking or falling asleep
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Other:	<input type="checkbox"/> Allergies
		<input type="checkbox"/> None

Please list all your medications, including over-the-counter meds and herbal remedies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies to medicine? If so, please list them: \_\_\_\_\_

\_\_\_\_\_

Do you have a history of: ( Please check all boxes that apply )

<input type="checkbox"/> Stroke or TIA	<input type="checkbox"/> Seizures/Other Neurological Diseases	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Drug or Alcohol Addiction	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Deviated Nasal Septum	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Anxiety

Past or Current Medical Problems: \_\_\_\_\_

\_\_\_\_\_

Past Surgeries: \_\_\_\_\_

\_\_\_\_\_

Have you had your tonsils removed?  Yes  No if so, at what age? \_\_\_\_\_

# Webster Dental Care

## Patient Questionnaire

Occupation: \_\_\_\_\_

Do you smoke?  Yes  No If so, for how many years and how much? \_\_\_\_\_

Do you drink Alcohol?  Yes  No If so, how many drinks per week? \_\_\_\_\_

Do you drink coffee, caffeinated soda, or tea?  Yes  No If so, how many cups per day? \_\_\_\_\_

**Please mark any of the below occurrences that either you or someone else has observed of you:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Snoring             | <input type="checkbox"/> Acting Out Dreams       | <input type="checkbox"/> Wake Up Gasping For Air           |
| <input type="checkbox"/> Leg Jerks           | <input type="checkbox"/> Nighttime Wheezing      | <input type="checkbox"/> Stop Breathing While Sleeping     |
| <input type="checkbox"/> Restless Sleep      | <input type="checkbox"/> Vivid Dreams/Nightmares | <input type="checkbox"/> Take Sleeping Medication          |
| <input type="checkbox"/> Talking In Sleep    | <input type="checkbox"/> Morning Headacheas      | <input type="checkbox"/> Creeping/Crawling Feeling In legs |
| <input type="checkbox"/> Teeth Grinding      | <input type="checkbox"/> Sleep Disrupting Ideas  | <input type="checkbox"/> Feel The Need To Move Your Legs   |
| <input type="checkbox"/> Sleep Walking       | <input type="checkbox"/> Awaken With Dry Mouth   | <input type="checkbox"/> Pain That Interferes With Sleep   |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Dementia                | <input type="checkbox"/> Excessive Sleepiness              |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Narcolepsy              | <input type="checkbox"/> Insomnia                          |
| <input type="checkbox"/> Sleep Apnea         | <input type="checkbox"/> None                    |  |

Have you ever had a Sleep study? \_\_\_\_\_ When: \_\_\_\_\_

Location of sleep study: \_\_\_\_\_ Doctor: \_\_\_\_\_

Have you ever had an oral appliance or ventilation equipment to treat a sleep or snoring problem? \_\_\_\_\_

What type: \_\_\_\_\_

Is your nighttime sleep refreshing  Yes  No

Are you sleepy/fatigued during the day  Yes  No If yes, what time of day is worse? \_\_\_\_\_

If you snore, what sleeping positions do you snore in?  Back  Side  Stomach

Does your snoring disturb others?  Yes  No

What positions do you sleep in:  Back  Side  Stomach

Mark any of the following that you do while you are in bed:

Read  Eat  Watch TV  Do work activities  Sleep with the TV on

How many times do you wake to use the restroom? \_\_\_\_\_

How long does it take you to fall back to sleep? \_\_\_\_\_ If you have difficulty falling asleep, what do you do? \_\_\_\_\_

Do you take naps?  Yes  No If yes, how long are they? \_\_\_\_\_

Do you dream during the naps?  Yes  No Are the naps refreshing?  Yes  No

Do you exercise?  Yes  No If yes, what time of day do you exercise? \_\_\_\_\_

Patient Name:

Patient Address:

Dear \_\_\_\_\_,

Welcome to our practice. We are delighted that you have chosen us for your Oral Appliance Therapy to treat your snoring or Obstructive Sleep Apnea. Our team is highly skilled and committed to making your experience at Webster Dental Care as pleasant as possible.

Enclosed are a Snoring and Sleep Apnea Questionnaire. Please fill out the forms completely, as your accurate history and symptoms are vital to our doctors during your first visit.

Also, please:

- Have your bed partner fill out the Bed Partner Survey
- Fill out the Epworth Sleepiness Scale
- Bring all forms completed to your appointment with you.

If you have any questions, please call our sleep coordinator, Paula at (847) 673-7118.

Your initial visit is on \_\_\_\_\_. Your initial examination and consultation fee is \$103.00. We appreciate the value of your time, and strive to be on time and answer any diagnosis, treatment and financial questions that you may have during your visit. If you have an emergency or unable to keep your appointment for any reason, please notify us as early as possible.

We look forward to seeing you.

Sincerely,

Webster Dental Care