Lyons Family Dentistry

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Sleep Assessment Form

Your physician is requesting that you complete this Sleep Assessment Form. This form determines the need for you to have a user friendly home sleep test, which will test to see if you have a challenge breathing when you are sleeping. How you breathe can affect your quality of life and especially your cardiovascular health; and can be easily treated.

Chart#: _____ FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ____ (MI)

_____ (Preferred Name)

Title: **Gender:** _____ (Mr/Ms/Mrs/etc) ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

Prev. Visit: _____

Email Address: _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext)

Best time to call: _____

Address: _____ (Address 1)

_____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

OK to leave a message? ◯ Yes ◯ No

Primary Physician's name and phone number:

_____

_____

1. Have you ever been given a CPAP device? ◯ Yes ◯ No

2. If you have been given any form of a CPAP, do you use it nightly? ◯ Yes ◯ No

3. Are you comfortable with your CPAP device and statisfied with its use? ◯ Yes ◯ No

If you answered YES to all of the above questions, PLEASE STOP.
If you answer is NO to any of the above questions, please continue to the following questions:

Epworth Sleepiness Scale

How likely are you to dose off while doing the following activities? Please use the following scale:
0= Never
1= Slight
2= Moderate

3= High

1. Being a passenger in a motor vehicle for an hour or more

○ 0 ○ 1 ○ 2 ○ 3

2. Sitting and talking to someone

○ 0 ○ 1 ○ 2 ○ 3

3. Sitting and reading

○ 0 ○ 1 ○ 2 ○ 3

4. Watching TV

○ 0 ○ 1 ○ 2 ○ 3

5. Sitting inactive in a public place

○ 0 ○ 1 ○ 2 ○ 3

6. Lying down to rest in the afternoon

○ 0 ○ 1 ○ 2 ○ 3

7. Sitting quietly after lunch without alcohol

○ 0 ○ 1 ○ 2 ○ 3

8. In a car, while stopped for a few minutes in traffic

○ 0 ○ 1 ○ 2 ○ 3

Part1

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1. Have you ever been told you snore? ○ Yes ○ No

2. Does your family have a history of premature death in sleep? ○ Yes ○ No

3. Do you have Diabetes? ○ Yes ○ No

4. Have you ever been told you have Coronary Artery Disease? ○ Yes ○ No

5. Have you ever been told you have high blood pressure? ○ Yes ○ No

6. Have you ever been told you have an irregular heart beat? ○ Yes ○ No

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Part 2

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1. Are you taking opiod pain medication on a regular basis? ○ Yes ○ No

2. Have you ever been diagnosed with sleep apnea? ○ Yes ○ No

3. Do you awaken from sleep with chest pain or shortness of breath? ○ Yes ○ No

4. Has anyone said that you seem to stop breathing while sleeping? ○ Yes ○ No

5. Is your neck size larger than 15" (female) or 16.5 (male)? ○ Yes ○ No

6. Have you ever had a stroke? ○ Yes ○ No

7. Have you ever been told you have congestive heart failure? ○ Yes ○ No

8. Do you have or did you ever have atrial fibrillation? ○ Yes ○ No

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Part 3

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1. Does snoring cause problems at home? ○ Yes ○ No

2. Would you like to fix that? (if yes to the above question) ◯ Yes ◯ No

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Part 4 (Completed by Assistant or Hygientist)

Neck Size: Excessive Neck Size (Female >15', Male >16.5) =1 diagnostice point _____

Height: _____

Weight: _____

Mallampati: (ClassIII or IV Greater=1 diagnostic point) _____

Scalloped tongue (Scalloped tongue=1 diagnostic point) _____

Physician Signature:

Signature _____

Date

Patient Signature:

Signature _____

Date

SA Score: _____

POS ◯ Yes ◯ No

NEG ◯ Yes ◯ No

HST AUTH: ◯ Yes ◯ No

Response Date: _____