

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 _____

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

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

(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.

Patient Signature _____

Date _____

Berlin

THE EPWORTH SLEEPINESS SCALE

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

√ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance 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><i>(Add columns 0-3)</i></p>

Patient Signature _____ Date _____