SLEEP SCREENING

Kent Burnett DDS

1711 NW Grant Ave,
Corvallis, OR 97330
(541) 754-1668

420 Smith St
Harrisburg, OR 97446
(541) 995-8234

Please email completed form to: office@kentburnettdds.com

NAME_____ DATE OF BIRTH_____

◯ Male ◯ Female

What are the chief complaints for which you are seeking treatment?

Please NUMBER you complaints with #1 being the most severe, #2 the next most severe, etc.

#1 = the most severe symptom, #13= the least severe symptom

- ☐ CPAP intolerance
- ☐ Difficulty concentrating
- ☐ Excessive daytime sleepiness
- ☐ Fatigue
- ☐ Forgetfulness
- ☐ Frequent snoring
- ☐ Gasping causing waking up
- ☐ Impaired thinking
- ☐ Insomnia
- ☐ Morning headaches
- ☐ Nighttime choking spells
- ☐ Snoring which effects the sleep of others
- ☐ Witnessed cessation of breathing

Other: Write in

_____ _____ _____ _____

SLEEP STUDIES

If you have had a sleep study, please check one of the following:

◯ Home Sleep Study ◯ Polysommnographic evaluation at a sleep disorder center

Sleep Center Name:_____ Date:_____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of _____

The evaluation showed:

		during REM	Supine	Side
an RDI of	☐	☐	☐	☐
an AHI of	☐	☐	☐	☐

a naidr SpO_2 of ☐ T90 ☐ ODI ☐ (Oxygen Desaturation Index)

Slow Wave Sleep ◯ Decreased ◯ None

REM Sleep ◯ Decreased ◯ None _____

CPAP Intolerance (Continuous Positive Airway Pressure)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section

- ◯ Refuses CPAP
- ◯ Mask leaks
- ◯ Inability to get mask to fit properly
- ◯ Discomfort from headgear
- ◯ Disturbed or interrupted sleep
- ◯ Noise disturbing sleep or bed partners sleep
- ◯ CPAP restricted movements during sleep
- ◯ CPAP does not seem to be effective
- ◯ Pressure on upper lip causing tooth problems
- ◯ Latex allergy
- ◯ Claustrophobic associations
- ◯ Unconscious need to remove CPAP mask
- ◯ Did not resolve symptoms
- ◯ Noisy
- ◯ Cumbersome

Other:_____

Other Therapy Attempts

Include:

- ○ Dieting
- ○ Weight loss
- ○ Surgery (Uvuloplasty)
- ○ Surgery (Uvulectomy)
- ○ Pillar procedure
- ○ Smoking cessation
- ○ CPAP
- ○ BiPAP
- ○ Uvuloplasty with continued symptoms
- ○ Uvulectomy with continued symptoms
- ○ Positional therapy – side sleeping
- ○ Nasal strips

Other:_____

Epworth Sleep Questionnaire

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

No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing	
○	○	○	○	Sitting and reading
○	○	○	○	Watching TV
○	○	○	○	Sitting inactive in public places (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 traffic

Fatigue Scale

During the past week:	NO< 1	2	3	4	5	6	7 >YES
I felt fatigued and had less motivation	○	○	○	○	○	○	○
I felt fatigued and did not desire to exercise	○	○	○	○	○	○	○
I felt fatigued often	○	○	○	○	○	○	○
I felt fatigue that interfered with my physical functioning	○	○	○	○	○	○	○
I felt fatigue which caused me frequent problems	○	○	○	○	○	○	○
I felt fatigue which prevented sustained physical functioning	○	○	○	○	○	○	○
I felt fatigued and couldn't carry out certain duties and responsibilities	○	○	○	○	○	○	○
Fatigue was among my three most disabling symptoms	○	○	○	○	○	○	○
Fatigue interfered with my work, family or social life	○	○	○	○	○	○	○

Patient Signature

Because of HIPAA federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your insurance company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

I certify that the medical history information is complete and accurate.

X _____ DATE_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR