Dr. A.M. Kahane, Inc

Ph: 250-423-6838
Fx: 250-423-6839
292 – 2nd Ave, Box 2818
Fernie, BC V0B 1M0
dentist@kahane.ca
www.kahane.ca

Sleep Screening Questionnaire

This questionnaire was designed to provide important facts regarding the history of your sleep condition. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible. Please sign each page.

Today's Date: _____

☐ Mr. ☐ Ms. ☐ Miss ☐ Mrs. ☐ Dr. Name: _____ (First / Middle Initial / Last)

Age: _____ Birthdate _____ (dd/mm/yy) ☐ Male ☐ Female

Address: _____ City: _____

Province: _____ Postal Code: _____ How Long at Current Address? _____

Previous Address (if less than 3yrs at current): _____

Employed By: _____ Occupation: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____ Responsible for Account: _____

Family Physician: _____ (Name / City / Phone)

Family Dentist: _____ (Name / City / Phone)

Please list any other health care practitioners seen in the last 9 months: _____

_____

Referred By: _____

Height: _____ feet _____ inches Weight: _____pounds

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

Please Number the complaints with #1 being the most important…

___ Frequent heavy snoring
___ which affects the sleep of others
___ Significant daytime drowsiness
___ I have been told that I stop breathing when sleeping
___ Difficulty falling asleep
___ Gasping when waking up
___ Nighttime choking spells
___ Feeling un-refreshed in the morning
___ Morning hoarseness
___ Morning headaches
___ Swelling in ankles or feet
___ Nocturnal teeth grinding
___ Jaw pain
___ Facial pain
___ Jaw clicking
___ _____ (Other)

Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center? ☐ Yes ☐ No

If yes:

Sleep Center Name: _____

Location: _____ Date: _____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of: ☐ mild ☐ moderate ☐ severe ☐ obstructive sleep apnea

The evaluation showed an RDI of _____ and an AHI of _____

Patient Signature: _____ Date: _____

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 due to:

- ☐ Mask leaks
- ☐ Discomfort caused by the straps and headgear
- ☐ CPAP restricted movements during sleep
- ☐ A latex allergy
- ☐ An unconscious need to remove the CPAP apparatus at night
- ☐ I was unable to get the mask to fit properly
- ☐ 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 does not seem to be effective
- ☐ Pressure on the upper lip causing tooth related problems
- ☐ Claustrophobic associations
- ☐ 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.)

_____

_____

List any medications which have caused an allergic reaction:

Y ☐ N ☐ Antibiotics
Y ☐ N ☐ Aspirin
Y ☐ N ☐ Barbiturates
Y ☐ N ☐ Codeine
Y ☐ N ☐ Iodine
Y ☐ N ☐ Latex
Y ☐ N ☐ Local Anesthetics
Y ☐ N ☐ Metals
Y ☐ N ☐ Penicillin
Y ☐ N ☐ Plastic
Y ☐ N ☐ Sedatives
Y ☐ N ☐ Sleeping Pills
Y ☐ N ☐ Sulfa Drugs

Other Allergies:
_____
_____
_____
_____
_____
_____

List any medications you are currently taking:

Y ☐ N ☐ Antacids
Y ☐ N ☐ Antibiotics
Y ☐ N ☐ Anticoagulants
Y ☐ N ☐ Antidepressants
Y ☐ N ☐ Anti-inflammatories (non-steroid)
Y ☐ N ☐ Barbiturates
Y ☐ N ☐ Blood Thinners
Y ☐ N ☐ Codeine
Y ☐ N ☐ Cortisone
Y ☐ N ☐ Diet Pills
Y ☐ N ☐ Heart Medication
Y ☐ N ☐ HPB Medication
Y ☐ N ☐ Insulin
Y ☐ N ☐ Muscle Relaxants
Y ☐ N ☐ Nerve Pills
Y ☐ N ☐ Pain Medication
Y ☐ N ☐ Sleeping Pills
Y ☐ N ☐ Sulfa Drugs
Y ☐ N ☐ Tranquilizers

Other Current Medications: _____
_____
_____
_____

Medical History:

Y ☐ N ☐ Anemia
Y ☐ N ☐ Arteriosclerosis
Y ☐ N ☐ Asthma
Y ☐ N ☐ Autoimmune Disorders
Y ☐ N ☐ Bleeding Easily
Y ☐ N ☐ Chronic Sinus Problems
Y ☐ N ☐ Chronic Fatigue
Y ☐ N ☐ Congestive Heart Failure
Y ☐ N ☐ Current Pregnancy
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Difficulty Concentrating
Y ☐ N ☐ Dizziness
Y ☐ N ☐ Emphysema
Y ☐ N ☐ Epilepsy
Y ☐ N ☐ Fibromyalgia
Y ☐ N ☐ Frequent Sore Throats
Y ☐ N ☐ GERD
Y ☐ N ☐ Hay Fever
Y ☐ N ☐ Heart Disorder
Y ☐ N ☐ Heart Murmur
Y ☐ N ☐ Heart Pounding During Night
Y ☐ N ☐ Heart Pacemaker
Y ☐ N ☐ Valve Replacement
Y ☐ N ☐ Heartburn (At Night)
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ High Blood Pressure
Y ☐ N ☐ Immune System Disorder
Y ☐ N ☐ Injury to:
☐ Face ☐ Neck ☐ Head
☐ Mouth ☐ Teeth
Y ☐ N ☐ Insomnia
Y ☐ N ☐ Irregular Heart Beat
Y ☐ N ☐ Jaw Joint Surgery
Y ☐ N ☐ Low Blood Pressure
Y ☐ N ☐ Memory Loss
Y ☐ N ☐ Migraines
Y ☐ N ☐ Morning Dry Mouth
Y ☐ N ☐ Muscle Spasms
Y ☐ N ☐ Needing Extra Pillows at Night
Y ☐ N ☐ Nighttime Sweating
Y ☐ N ☐ Osteoarthritis
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Poor Circulation
Y ☐ N ☐ Prior Orthodontic Treatment
Y ☐ N ☐ Recent Excessive Weight Gain
Y ☐ N ☐ Rheumatic Fever
Y ☐ N ☐ Shortness of Breath
Y ☐ N ☐ Swollen, stiff, painful joints
Y ☐ N ☐ Thyroid Problems
Y ☐ N ☐ Tonsillectomy (have had)
Y ☐ N ☐ Wisdom Teeth Extraction

Other Medical History:
_____
_____
_____
_____
_____
_____

Patient Signature: _____ Date: _____

Family History:

1. Have any members of your family (blood kin) had: Yes ☐ No ☐ Heart Disease
   Yes ☐ No ☐ High Blood Pressure
   Yes ☐ No ☐ Diabetes

2. Have any immediate family members been diagnosed or treated for a sleep disorder? Yes ☐ No ☐

Social History:

Alcohol consumption:
How often do you consume alcohol within 2-3 hours of bedtime?
☐ Never ☐ Once a Week ☐ Several Days a Week
☐ Daily ☐ Occasionally

Sedative Consumption:
How often do you take sedatives within 2-3 hours of bedtime?
☐ Never ☐ Once a Week ☐ Several Days a Week
☐ Daily ☐ Occasionally

Caffeine Consumption:
How often do you consume caffeine within 2-3 hours of bedtime?
☐ Never ☐ Once a Week ☐ Several Days a Week
☐ Daily ☐ Occasionally

Do you smoke? ☐ Yes ☐ No
If yes, enter the number of packs per day (or other description of quantity):
_____

Do you use chewing tobacco? ☐ Yes ☐ No

Additional Comments:

Is there anything else you feel the doctor should know?
_____
_____
_____
_____
_____
_____

I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

_____
Patient Signature

Patient Signature: _____ Date: _____