Sleep Health Questionnaire

☐ M ☐ F / /

Patient Name | Gender | DOB

Address, City, State | Zip

Cell Phone | Alt. Phone | Email

Medical Insurance Company | ID# | Group#

FOR PATIENT USE

Patient Sleepiness Scale (Risk Factors): *Please check all that apply.*		**pt.**	*Additional comments below:*
1. I have been told I stop breathing while asleep	☐	8	
2. I have fallen asleep or nodded off while driving	☐	6	
3. I've woken up with shortness of breath / gasping or my heart racing	☐	6	
4. I feel excessively sleepy or fatigued during the day	☐	4	
5. I snore or have been told that I snore	☐	4	
6. I have had weight gain and found it difficult to lose	☐	4	
7. I have been diagnosed with high blood pressure	☐	4	
8. It takes me less than 10 minutes to fall asleep	☐	4	
9. I wake up more than 1 time per night	☐	4	
10. I wake up with headaches	☐	4	

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Total points from above _____ .Check your Risk Level Score: ☐ **Low:** *0-7* ☐ **Moderate:** *8-11* ☐ **High:** *12-15* ☐ **Severe:** *16+*

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Patient Health History (Signs & Symptoms): *Please check all that apply.*

- ☐ Snoring
- ☐ Depression/Anxiety
- ☐ Unrefreshed Upon Waking
- ☐ Witnessed Choking/Gasping/Apnea
- ☐ Irritability/Moodiness
- ☐ Wakes Up with Dry Mouth
- ☐ Sinus/Allergy Issues
- ☐ Grind Teeth
- ☐ Diabetes
- ☐ History of Stroke/Heart Disease
- ☐ Acid Reflux/GERD
- ☐ Hypertension
- ☐ Memory Loss
- ☐ Family History of OSA/Snoring
- ☐ Deviated Septum
- ☐ Currently Not Using Prescribed CPAP

I authorize this practice to release any medical information for the purpose of the coordination of care.

Patient Signature **Date**

Ask your dentist to complete.

- ☐ BMI > 30 (see reverse)
- ☐ Narrow upper arch
- ☐ Visual airway obstruction
- ☐ Large/scalloped tongue
- ☐ Neck size: Male ≥ 17" or Female ≥ 16"

_____ ' _____ "
Height

_____ lbs
Weight

_____ inches
Neck Size

_____
Blood Pressure

_____ BPM
Heart Rate

_____
BMI

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Prescription / Statement of Medical Necessity

*Certain insurance payers require a minimum **Risk Level Score of High** and/or **at least two (2) Signs & Symptoms**; sometimes up to four (4).*

Home sleep study (*G47.33 to be used to rule out OSA, unless stated differently. If other, please specify):* _____

- ■ **Baseline 2-Night or (_____-Night) home sleep study**
- ☐ **Assessment of oral appliance efficacy**

I certify that above home sleep test is medically indicated and is reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

AS

Dr. Signature State Lic#: 31829 **Date** Account Code

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