

# SLEEP DISORDERED BREATHING REPORT

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## I. Subjective Information

### A. Summary of Sleep Complaints

#### Chief Complaint

Snoring: \_\_\_\_\_ Sleepiness: \_\_\_\_\_ Fatigue: \_\_\_\_\_ Other: \_\_\_\_\_

#### Snoring

1. Do you snore no matter what position you are lying in? Yes No Do Not Know
2. Do you snore every night? Yes No Do Not Know
3. Is your snoring interrupted by pauses and/or choking sounds? Yes No Do Not Know
4. Has your sleep mate ever commented on your snoring? Yes No NA
5. Does your snoring result in sleeping in separate bedrooms? Yes No NA
6. On a scale of 1-10 with 10 being loudest, how loud is your snoring: \_\_\_\_\_
7. Other comments: \_\_\_\_\_

#### Sleepiness/Fatigue

1. How would you describe yourself? (Check all that apply)  
Fatigued: \_\_\_\_\_ Sleepy: \_\_\_\_\_ Tired: \_\_\_\_\_ Other: \_\_\_\_\_
2. What tasks or activities have you eliminated or find difficulty in completing?  
\_\_\_\_\_  
\_\_\_\_\_
3. What is your energy level on a scale of 1-10?  
No energy 1 2 3 4 5 6 7 8 9 10 Very high energy
4. Other comments: \_\_\_\_\_

#### Sleep

1. Average time you go to sleep? \_\_\_\_\_ wake up? \_\_\_\_\_
2. How long does it take you to fall asleep? \_\_\_< 1 min \_\_\_<5min \_\_\_<15min \_\_\_>15min
3. How often do you awake during the night (bathroom, clock, noises, etc...)? \_\_\_\_\_
4. Is it difficult to fall back asleep if you awake during the night? Yes No
5. What is the quality of your sleep? Very Poor 1 2 3 4 5 6 7 8 9 10 Excellent
7. Do you take any medications or other products for sleeping? \_\_\_Yes \_\_\_No  
Please list \_\_\_\_\_
8. Do you take naps routinely \_\_\_Yes \_\_\_No
9. Other comments: \_\_\_\_\_

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**Nasal conditions**

Are you able to breathe easily through your nose? \_\_\_Yes \_\_\_No

Are you nasally congested during the day? \_\_\_Yes \_\_\_No

Is your nasal congestion worse at night? \_\_\_Yes \_\_\_No

Do you experience nasal allergies resulting in intermittent nasal blockage?

\_\_\_Yes \_\_\_No Medications for allergies \_\_\_none \_\_\_shots \_\_\_nasal sprays  
\_\_\_nasal steroids \_\_\_oral decongestants

Do you breathe through your mouth \_\_\_never \_\_\_most of the time \_\_\_at night?

Do you wake with a sore throat? \_\_\_Yes \_\_\_No Dry mouth \_\_\_Yes \_\_\_No

Other problems \_\_\_\_\_

**Other conditions or symptoms that may be related (check all that apply)**

- |                            |                             |
|----------------------------|-----------------------------|
| ___ Asthma                 | ___ Hoarseness              |
| ___ Chronic sinus problems | ___ Use of nasal sprays     |
| ___ COPD                   | ___ Insomnia                |
| ___ Depression             | ___ Impotence               |
| ___ Diabetes               | ___ Memory loss             |
| ___ Emphysema              | ___ Migraines               |
| ___ Fibromyalgia           | ___ Reflux                  |
| ___ Stroke                 | ___ Recent weight gain      |
| ___ Headache               | ___ Swelling in extremities |
| ___ High blood pressure    | ___ Teeth grinding          |
| ___ High cholesterol       | ___ Thyroid disorder        |

**History of evaluation or treatment of sleep disordered breathing**

Have you ever been evaluated or treated for your snoring or sleep apnea? Yes \_\_\_ No\_\_\_  
(If yes please continue)

Overnight sleep study (PSG) \_\_\_Yes \_\_\_No Date \_\_\_\_\_

Name of physician or center \_\_\_\_\_

Address \_\_\_\_\_

Diagnosis: \_\_\_don't know \_\_\_simple snoring \_\_\_mild apnea \_\_\_moderate apnea  
\_\_\_severe apnea \_\_\_other \_\_\_\_\_

Treatment options or recommendations: \_\_\_weight loss \_\_\_surgery \_\_\_cpap  
\_\_\_oral appliance \_\_\_other \_\_\_\_\_

<p><b>For office use only</b></p> <p>RDI/AHI _____, SpO<sub>2</sub>&lt;90% _____, Lowest SpO<sub>2</sub> _____.</p> <p>Diagnosis: mild___ moderate___ severe___ OSA</p> <p>Physician _____</p> <p>___A copy of the sleep study is included</p>
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Weight loss attempted \_\_\_Yes \_\_\_No Amount lost \_\_\_\_\_ Amount regained \_\_\_\_\_

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Surgical treatment  Yes  No Date \_\_\_\_\_

Type of surgery:  UPPP (palatal surgery)  LAUP (laser palatal surgery)  
 nasal surgery  somnoplasty  Pillar  Jaw surgery  Bariatric  
 other \_\_\_\_\_

Results of surgery:  reduced sleep apnea and snoring permanently \_\_\_\_%  
 reduced or eliminated sleep apnea and/or snoring \_\_\_\_% initially but  
symptoms have returned  
 I gained no benefit from the surgery

Symptoms caused by surgery:

Having fluid or food pass into your nose when you swallow  
 A change in how your voice sounds  
 Pain in the throat when swallowing  
 Coughing  
 Other \_\_\_\_\_

#### CPAP

I was offered a trial of cpap but decided to try other options first.  
 I tried cpap during a sleep study but could not wear it.  
 I am presently wearing a cpap  Yes  No  
Number of days per week \_\_\_\_\_ Number of hours per day \_\_\_\_\_  
Date started using cpap \_\_\_\_\_ Type of mask \_\_\_\_\_  
 I feel refreshed and well rested every morning  
 It helps, but I still feel tired or unrefreshed  
 I feel no better with the cpap  
 I tried wearing a cpap for \_\_\_\_ months but discontinued.

#### Symptoms with cpap

runny nose  
 stuffed, congested, blocked nose  
 excessive dryness of the nose or throat passages especially on awakening  
 soreness in the nose or throat passages  
 headaches  
 eye irritation  
 ear pain  
 waking up frequently during the night  
 difficulty returning to sleep if awakened  
 air leakage from the mask  
 discomfort from the mask  
 marks or rash on the face  
 allergy to the mask  
 complaints from the bedpartner about cpap  
 claustrophobia  
 unconscious removal of the mask  
 other \_\_\_\_\_

\_\_\_\_\_Initials

**B. Past History**

**Medical History**

- \_\_\_\_\_ AIDS/HIV
- \_\_\_\_\_ Anemia
- \_\_\_\_\_ Arthritis
- \_\_\_\_\_ Bladder Disease
- \_\_\_\_\_ Bleeding Disorders
- \_\_\_\_\_ Breathing Problems
- \_\_\_\_\_ Cancer
- \_\_\_\_\_ Chronic fatigue
- \_\_\_\_\_ Dizziness
- \_\_\_\_\_ Epilepsy
- \_\_\_\_\_ Glaucoma
- \_\_\_\_\_ Hearing Loss

- \_\_\_\_\_ Heart Disease
- \_\_\_\_\_ Hepatitis
- \_\_\_\_\_ Liver Disease
- \_\_\_\_\_ Mitral Valve Prolapse
- \_\_\_\_\_ Low Blood Pressure
- \_\_\_\_\_ Prostate Problems
- \_\_\_\_\_ Pregnant
- \_\_\_\_\_ Shortness of Breath
- \_\_\_\_\_ Tuberculosis
- \_\_\_\_\_ Ulcers
- \_\_\_\_\_ Kidney Disease

Have you been under the care of a physician in the last year for anything other than a routine physical. \_\_\_Yes \_\_\_No

If yes, please explain \_\_\_\_\_

List any major illnesses in the past five years \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_Initials

**Surgical history**

List any surgical procedures including childhood surgeries \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications**

It is helpful for your physician to know about the types of medications you are currently taking. Because many people cannot recall details of the prescriptions or over-the-counter medications at the doctor's office, complete this form to bring to your appointment.

<b>Name</b>	<b>Purpose</b>	<b>Dosage</b>	<b>Length of time</b>
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

**Medication allergies**

Please list \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Dental History:**

- |  |     |    |
|--|-----|----|
| 1. Have you ever had orthodontic treatment (braces)?               | Yes | No |
| 2. Have teeth been removed for orthodontic reasons                 | Yes | No |
| 3. Are your teeth sensitive to hot or cold?                        | Yes | No |
| 4. Are you aware of a tired feeling your face:                     | Yes | No |
| 5. Do you have ringing or pain in your ears:                       | Yes | No |
| 6. Do you clench or grind your teeth?                              | Yes | No |
| 7. Do you have frequent headaches?                                 | Yes | No |
| 8. Do you have pain around your ears, eyes, head, or neck?         | Yes | No |
| 9. Have you been diagnosed with a temporomandibular disorder (TMJ) | Yes | No |
| 10. Do you have any loose teeth                                    | Yes | No |
| 11. Do you have any dental prosthesis (crowns, dentures)           | Yes | No |
| 12. Do you have any dental problems                                | Yes | No |

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Initials

