PHILLIPS SCHMITT
DDS, PA

1111 Hendersonville Road • Asheville, NC 28803
828.254.1944 • psdentistry.com

SLEEP QUESTIONNAIRE

Patient Name: ______________________________ Date of Birth: ____________________

ALTERNATIVE THERAPIES

a. Have you attempted CPAP therapy? .... ☐ Yes ☐ No

-If yes, are you able to use it at least 5 nights a week (4 or more hours per night)? [I] ☐ Yes ☐ No

b. Have you undergone any surgical attempts to correct your OSA? .... ☐ Yes ☐ No

c. Have you tried any of the following conservative methods of improving your sleep breathing? (please check)

- ☐ Weight loss
- ☐ Positional therapy (avoiding the supine position during sleep)
- ☐ Abstaining from the use of alcohol and/or sedatives before bedtime

STOP-BANG [II] (Also refer to physical evaluation form)

d. Do you snore loudly?.. Yes ☐ No

e. Do you often feel tired or fatigued after sleep? .... Yes ☐ No

f. Has anyone noticed that you quit breathing during sleep? .... Yes ☐ No

g. Do you take medication for high blood pressure? .... ☐ Yes ☐ No

EPWORTH SLEEP QUESTIONNAIRE [III]

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would affect you. Use the following scale to choose the most appropriate number for each situation. (Please circle the number to answer)

	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
h. Sitting and reading	0	1	2	3
i. Watching TV	0	1	2	3
j. Sitting inactive in a public area (e.g., a theater)	0	1	2	3
k. As a passenger in a car for an hour without a break	0	1	2	3
l. Lying down to rest in the afternoon	0	1	2	3
m. Sitting and talking to someone	0	1	2	3
n. Sitting quietly after lunch without alcohol	0	1	2	3
o. In a car stopped for a few minutes in traffic	0	1	2	3

I. Citation for CPAP compliance as 5 nights a week for 4 or more hours each night: Positive Airway Pressure Devices (A48132). www.cms.gov
II. J Cin Sleep Med 2011;7(5):467-472
III.Johns MW. A new method for measuring daytime sleepiness: Epworth sleepiness scale. Sleep 1991;14:540-5

PHILLIPS | SCHMITT
DDS, PA

1111 Hendersonville Road • Asheville, NC 28803
828.254.1944 • psdentistry.com

PATIENT REGISTRATION

ID: ________ Chart ID: ________

First Name: ________ Last Name: ________ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: ________

Responsible Party (if someone other than the patient)

First Name: ________ Last Name: ________ Middle Initial: ____

Address: ________ Address 2: ________

City, State, Zip: ________ Pager: ________

Home Phone: ________ Work Phone: ________ Ext: ____ Cellular: ________

Birth Date: ________ Soc Sec: ________ Drivers Lic: ________

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ________ Address 2: ________

City: ________ State / Zip: ____ ________ Pager: ________

Home Phone: ________ Work Phone: ________ Ext: ____ Cellular: ________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ________ Age: ____ Soc. Sec: ________ Drivers Lic: ________

E-mail: ________ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ________ Pref. Dentist: ________

Employer ID: ________ Pref. Pharmacy: ________

Carrier ID: ________ Pref. Hyg.: ________

Section 3

cell phone: ________

preferred name: ________

name pronounced: ________

emergency contact: ________

emergency contact #: ________

Primary Insurance Information

Name of Insured: ________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________
Address: ________
Address 2: ________
City,State,Zip: ________

Ins. Company: ________
Address: ________
Address 2: ________
City,State,Zip: ________

Rem. Benefits: ________.00 Rem. Deduct: ________.00

Secondary Insurance Information

Name of Insured: ________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________
Address: ________
Address 2: ________
City,State,Zip: ________

Ins. Company: ________
Address: ________
Address 2: ________
City,State,Zip: ________

Rem. Benefits: ________.00 Rem. Deduct: ________.00