HomeSleep DENTAL

Dental Sleep Questionnaire

FAX COMPLETED FORM TO 855-967-1112

PATIENT INFORMATION:

Name: _____ Date: _____

1. Do you snore loudly or have been told that you snore? YES ❑ NO ❑
2. Do you ever awaken with a sensation of gasping or choking? YES ❑ NO ❑
3. Has anyone ever noticed that you stop breathing during your sleep? YES ❑ NO ❑
4. Do you often wake up with a dry mouth? YES ❑ NO ❑
5. Do you find your sleep to be non-refreshing? YES ❑ NO ❑
6. Do you often feel tired, fatigued, or sleepy during daytime? YES ❑ NO ❑
7. Do you ever fall asleep or nod off in situations where you did not intend to? YES ❑ NO ❑
8. Do you have (or are being treated for) high blood pressure and/or diabetes? YES ❑ NO ❑

If you answered **YES** to **3 or more** questions, you are a candidate for a Home Sleep Test to evaluate for the presence of Obstructive Sleep Apnea.

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices. I authorize HomeSleep, LLC to obtain any and all medical record pertaining to past medical history of sleep apnea.

PCP NAME _____ PCP Telephone _____

Signature _____

**This questionnaire utilizes portions of the Berlin questionnaire, Epworth Sleepiness Scale (ESS), and STOP-BANG questionnaire, which are widely recognized by the AASM as screening tools for obstructive sleep apnea (OSA).*