

Sleep Health Questionnaire

☐ M ☐ F

/ /

Patient Name

Gender

DOB

Address, City, State

Zip

Cell Phone

Alt. Phone

Email

Medical Insurance Company

ID#

Group#

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

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

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

Ask your dentist to complete.

☐ Snoring

☐ Diabetes

☐ Depression/Anxiety

☐ History of Stroke/Heart Disease

☐ Unrefreshed Upon Waking

☐ Acid Reflux/GERD

☐ Witnessed Choking/Gasping/Apnea

☐ Hypertension

☐ Irritability/Moodiness

☐ Memory Loss

☐ Wakes Up with Dry Mouth

☐ Family History of OSA/Snoring

☐ Sinus/Allergy Issues

☐ Deviated Septum

☐ Grind Teeth

☐ Currently Not Using Prescribed CPAP

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

Height

Weight

Neck Size

Blood Pressure

BPM

Heart Rate

BMI

Patient Signature

Date

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.

NPI#:

Office Contact:

Phone:

Dr. Signature

State Lic#:

Date

Account Code



FOR PATIENT USE

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FOR OFFICE USE

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