Design Dentistry/Northwest Oral Health PC
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Name _____ DOB_____ Gender ◊ M ◊ F

Address_____City_____State_____Zip_____

Weight_____ Height_____ Neck Size_____ Cell Phone_____

Alt. Phone_____ Email_____

PPO Medical Insurance Company (Non-PPO)_____

ID#_____ Group#_____

Have you ever been diagnosed with a sleep disorder? YES / NO
Night time oxygen use? YES / NO
Are you currently using a CPAP Machine? YES / NO (If YES) Do you use it every night? YES / NO

Answer "YES" or "NO" to the following questions (Circle Yes or No answers)

Y	N	8	Have you ever been told you stop breathing while asleep?
Y	N	6	Have you ever fallen asleep or nodded off while driving?
Y	N	6	Have you ever woken up suddenly with shortness of breath, or with your heart racing?
Y	N	4	Do you feel excessively sleepy during the day?
Y	N	4	Do you snore or have you ever been told that you snore?
Y	N	2	Have you had weight gain and found it difficult to lose?
Y	N	2	Have you taken medication for, or been diagnosed with high blood pressure?
Y	N	3	Do you kick or jerk your legs while sleeping?
Y	N	3	Do you feel burning, tingling or crawling sensations in your legs when you wake up?
Y	N	3	Do you wake up with headaches during the night or in the morning?
Y	N	4	Do you have trouble falling asleep?
Y	N	4	Do you have trouble staying asleep once you fall asleep?

Score and Risk Factor (Add the points that you have answered "YES")

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

FOR OFFICE USE/NEXT STEPS:

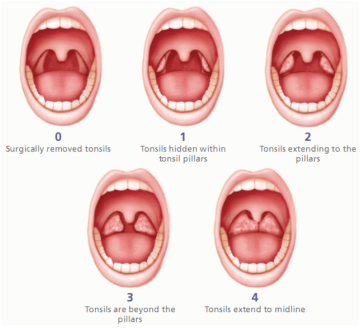
◊Home Sleep Test ($152) Taken _____ ◊ Sleep Specialist Consultation Scheduled _____
◊Overnight attended Polysomnogram Scheduled _____ ◊ENT Referral _____
◊Patient elects to do nothing at this time _____
Notes _____

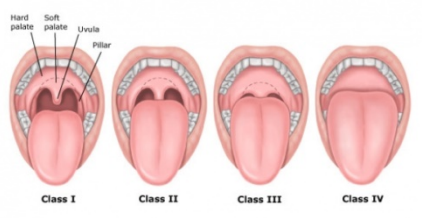
The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure

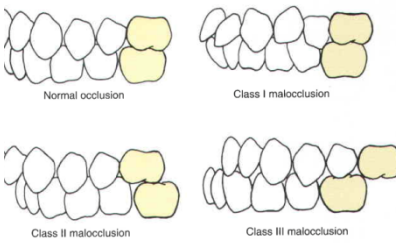
Dr. Signature _____ Date_____

State License WA #60069344 NPI #1558541458 Personal #1861884983

Airway Evaluator







□ Clenching/Grinding

□ Nasal septum deviation

□ Anterior gingivitis

□ Periodontal disease

□ Battered uvula

□ Acid erosion/cupping in cusp area

□ Scalloped tongue

□ Macroglossia

□ Tongue tie _____%

□ Bags under the eyes

□ Double chin

□ Pharyngeal walls

□ Mouth breathing

□ Headaches/when/where

□ High arched palate

□ Nasal congestion

□ Overbite greater than 80%

□ Pre-molar extraction

□ Abfraction

□ Forward wear pattern

□ Lingual tori

□ Palatal tori/exostoses

□ Forward head posture

□ Lingualized dentition

□ Allergies/Medication

□ Gag reflex

□ Overclosure