

List any medications which have caused an allergic reaction:

- Y N Antibiotics
 Y N Aspirin
 Y N Barbiturates
 Y N Codeine
 Y N Iodine
 Y N Latex
 Y N Local anesthetics

- Y N Metals
 Y N Penicillin
 Y N Plastic
 Y N Sedatives
 Y N Sleeping pills
 Y N Sulfa drugs

Other allergens:

List any medications you are currently taking:

- Y N Antacids
 Y N Antibiotics
 Y N Anticoagulants
 Y N Antidepressants
 Y N Anti-inflammatory drugs
 (non-steroid)
 Y N Barbiturates
 Y N Blood thinners

- Y N Codeine
 Y N Cortisone
 Y N Diet pills
 Y N Heart medication
 Y N High blood pressure medication
 Y N Insulin
 Y N Muscle relaxants
 Y N Nerve pills

- Y N Pain medication
 Y N Sleeping pills
 Y N Sulfa drugs
 Y N Tranquilizers

Other current medications:

Medical History

- Y N Anemia
 Y N Arteriosclerosis
 Y N Asthma
 Y N Autoimmune disorders
 Y N Bleeding easily
 Y N Chronic sinus problems
 Y N Chronic fatigue
 Y N Congestive heart failure
 Y N Current pregnancy
 Y N Diabetes
 Y N Difficulty concentrating
 Y N Dizziness
 Y N Emphysema
 Y N Epilepsy
 Y N Fibromyalgia
 Y N Frequent sore throats
 Y N Gastroesophageal Reflux
 Disease (GERD)
 Y N Hay fever
 Y N Heart disorder
 Y N Heart murmur
 Y N Heart pounding or beating
 irregularly during the night

- Y N Heart pacemaker
 Y N Heart valve replacement
 Y N Heartburn or a sour taste
 in the mouth at night
 Y N Hepatitis
 Y N High blood pressure
 Y N Immune system disorder
 Y N Injury to
 Face Neck
 Head Mouth Teeth
 Y N Insomnia
 Y N Irregular heart beat
 Y N Jaw joint surgery
 Y N Low blood pressure
 Y N Memory loss
 Y N Migraines
 Y N Morning dry mouth
 Y N Muscle spasms or
 cramps
 Y N Needing extra pillows to
 help breathing at night
 Y N Nighttime sweating

- Y N Osteoarthritis
 Y N Osteoporosis
 Y N Poor circulation
 Y N Prior orthodontic treatment
 Y N Recent excessive weight
 gain
 Y N Rheumatic fever
 Y N Shortness of breath
 Y N Swollen, stiff or painful
 joints
 Y N Thyroid problems
 Y N Tonsillectomy (have had)
 Y N Wisdom teeth extraction

Other medical history:

Patient Signature _____

Date _____

Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center? Yes No

If Yes:

Sleep Center Name _____
and Location _____

Sleep Study Date _____

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The evaluation confirmed a diagnosis of: *mild*
 moderate obstructive sleep apnea
 severe

The evaluation showed an RDI of _____ and an AHI of _____

CPAP Intolerance (Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to:

- mask leaks
- I was unable to get the mask to fit properly
- discomfort caused by the straps and headgear
- disturbed or interrupted sleep caused by the presence of the device
- noise from the device disturbing my sleep and/or bed partner's sleep
- CPAP restricted movements during sleep
- CPAP does not seem to be effective
- pressure on the upper lip causing tooth related problems
- a latex allergy
- claustrophobic associations
- an unconscious need to remove the CPAP apparatus at night

Other: _____

Other Therapy Attempts

What other therapies have you had for breathing disorders?
(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

Patient Signature _____

Date _____

Berlin Questionnaire Sleep Evaluation

1. Complete the following:

height _____ age _____
weight _____ male/female _____

2. Do you snore?

- yes
 no
 don't know

If you snore:

3. Your snoring is?

- slightly louder than breathing
 as loud as talking
 louder than talking
 very loud. Can be heard in adjacent rooms

4. How often do you snore?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

5. Has your snoring ever bothered other people?

- yes
 no

6. Has anyone noticed that you quit breathing during your sleep?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

7. How often do you feel tired or fatigued after your sleep?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?

- yes
 no

If yes, how often does it occur?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

10. Do you have high blood pressure?

- yes
 no
 don't know

(For office use)

Scoring Questions: Any answer within the box outline is a positive response

Scoring categories:

- Category 1 is positive with 2 or more positive responses to questions 2-6
Category 2 is positive with 2 or more positive responses to questions 7-9
Category 3 is positive with 1 positive response and/or a BMI > 30 (BMI = Body Mass Index)

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

THE EPWORTH SLEEPINESS SCALE

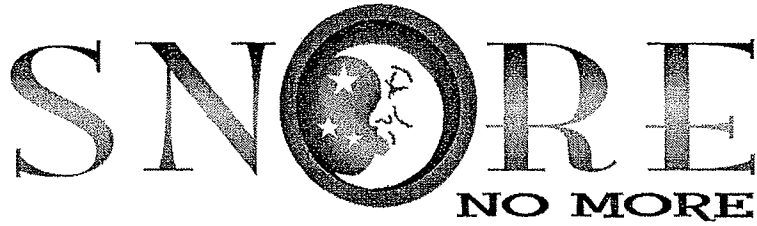
How likely are you to doze off or fall asleep in the following situations?

√ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>Total Score: _____</p> <p><i>(Add columns 0-3)</i></p>

Patient Signature _____

Date _____



PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

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