PARKFIELD DENTAL PRACTICE DIDSBURY

Your Details

First Name

Surname

Date of Birth

Address

Postcode

Telephone

Mobile

Email

Patient Occupation

Is your inquiry urgent?

General Medical Practitioner (Doctor) Details

GP Name

GP Phone Number

Health / Medical centre name

Health / Medical centre address

Health / Medical centre postcode

Dentist Details

Dentist Name

Dentist's Practice name

Dentist Addrress

Dentist Postcode

488FA2

This is a pre-assessment screening questionnaire. It provides important baseline information which will be treated in strict confidence.

What is your main concern or that of your sleeping partner?

Snoring

Bruxism / Tooth Grinding

Sleep Apnoea

Temperomandibular Jaw Joint (TMD) pain

Do you snore?

How loud do you snore?

Do you habitually sleep on your back?

Does your jaw fall open during sleep?

Do you awake from sleep feeling choked?

Do you have trouble breathing through your nose at night?

Do you awake at night to pass water?

Do you have a dry mouth or throat in the morning?

Do you suffer from headaches in the morning?

What time do you usually go to sleep?

What time do you wake up?

Do you suffer from tinnitus?

BMI calculator - please enter you weight and height below

bmi	weight(Lbs)	height(feet/inches)	weight(KGs)	height(cm)

STOP BANG QUESTIONNAIRE
In the questions below, please take **0** to be **NO** and **1** to be **YES**

STOP BANG Questions

#1 Do you Snore loudly (louder than talking or loud enough to be heard through closed doors?):

#2 Do you feel Tired, fatigued or sleepy during the day?:

#3 Has anyone Observed you stopping breathing during your sleep?:

#4 Do you have or have you been treated for high blood Pressure?:

#5 BMI more than 35kg/m2?:

#6 Age over 50 years old?:

#7 Neck circumference > 16 inches/40cm?:

#8 Gender: Male?:

Your STOP BANG Score is

High risk of Obstructive Sleep Apnoea ≥ 3
Low risk of Obstructive Sleep Apnoea < 3

Blood Pressure (if known)

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:-
0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SITUATION - CHANCE OF DOZING (Use slider to show your answer)

#1 Sitting and reading:

#2 Watching TV: 0

#3 Sitting, inactive in a public place (e.g. a theatre or a meeting):

#4 As a passenger in a car for an hour without a break:

#5 Lying down to rest in the afternoon when circumstances permit:

#6 Sitting and talking to someone:

#7 Sitting quietly after a lunch without alcohol:

#8 In a car, while stopped for a few minutes in the traffic:

Your Epworth Score is

SCORE 0 - 10 Normal Range | 10 - 12 Borderline | 12 - 24 Abnormal

Previous efforts to treat sleep disorder

Conservative regimens (e.g. weight loss, exercise):

Have you tried an oral appliance before?

Nasal continuous positive airway pressure (CPAP):

Weekly alcohol intake (units)

Daily cigarette intake (per day)

Previous sleep study:

Hospital Consultations

Consultant Name

Hospital Name

Hospital Address

Date last attended

Sleep Partner Questions

Sleep Partner's Name

We are looking to see whether your partner has problems with their breathing during their sleep.

Your answers may be shared with your sleeping partner and in strict confidence.

Does your partner stop breathing during their sleep?

How many times a night does your partner stop breathing during their sleep?

Is your partner very restless in their sleep?

Does your partner snore very loudly in their sleep?

Has the noise been so bad that you have to sleep in another room?

Has your partner's personality changed lately?

Does your partner fall asleep during the day?

Has your partner ever fallen asleep when driving a vehicle?

How likely is your partner to doze off or fall asleep in the following situations, in contrast to feeling just tired?
This refers to their usual way of life. Even if they haven't done some of these things recently, try and work out how they would be affected.

Use the following scale to choose the most appropriate number for each situation:
0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SLEEP PARTNER SITUATION - CHANCE OF DOZING (Use slider to show your answer)

#1 Sitting and reading:

#2 Watching TV:

#3 Sitting, inactive in a public place (e.g. a theatre or a meeting):

#4 As a passenger in a car for an hour without a break:

#5 Lying down to rest in the afternoon when circumstances permit:

#6 Sitting and talking to someone:

#7 Sitting quietly after a lunch without alcohol:

#8 In a car, while stopped for a few minutes in the traffic:

Your Sleep Partner's Epworth Score is

Medical History Questions

To offer the best and most appropriate care, please provide us with as much detail as possible about your medical history.

Are You:

Receiving treatment from your doctor or hospital?

Details about treatment you are receiving from your doctor or hospital

Pregnant or likely to be so?

Taking any medication? (e.g. tablets, ointments, inhalers - including contraceptives and hormore replacement therapy)

(Please tell us more below)

Please list medication below:

Have you:

any allergies (eg penicillin, substances (eg latex, rubber) or foods?

heart problems, heart surgery, angina, blood pressure problems, or stroke?

(Please tell us more below)

Please tell us more about your heart or blood pressure problems

had rheumatic fever or chorea? Yes/No

had liver disease (eg jaundice, hepatitis) or kidney disease?

asthma, bronchitis, or other chest conditions?

ever had a blood refused from the Blood Transfusion Service?

ever had a bad reaction to general or local anaesthetic?

any close relative (parent, sibling, child, grandparent or grandchild) with Creautzfeldt Jakob disease?

arthritis?

a joint replacement or other implant?

any other serious illness?

Do you...

experience fainting attacks, giddiness, blackoutsor epilepsy?

carrying a medical warning card?

bruise or bleed excessively following injury, tooth extraction or surgery?

suffer from infectious diseases (including HIV and hepatitis)?

Are you diabetic (or is anyone in your family)?

Is there any other information which your dentist might need to know about, such as self-prescribed medicines (eg aspirin)?

Your patient journey & consent for care at Parkfield Dental Practice

Please confirm that you have read Your patient journey & consent for care at Parkfield Dental [redacted] You can read this here.

I confirm I have read the patient journey and consent for care at Parkfield Dental Practice. When you consent for treatment this includes consent for all screening questionnaires, clinical assessments and sleep studies to be shared with your general doctor and hospital consultants to appropriately manage your care safely and to ensure the best possible outcome.

DVLA Guidance for UK drivers with Sleep Apnoea.

Please confirm that you have read and agree with the recommendations and responsibilities of a person with the sleep apnoea and their driving licence. You can read this here [redacted]

I confirm I have read the DVLA Guidance for UK Drivers with Sleep Apnoea

Sign & Date

Signature

Today's Date

I confirm that by submitting my details on this form I am giving you permission to securely store my details and use them where appropriate.