PRE-CONSULTATION QUESTIONNAIRES FOR SOMNOWELL DEVICE

Pre-Consultation Questionnaire

Please answer all questions and bring this form with you to the consultation.

Surname:.....First Name:.....Date of Birth:.....

Address:.....

.....

Telephone:
(home).....
(mobile).....

Postcode:.....

Email:.....

General Medical Practitioner (Doctor):

.....

.....

Postcode:.....

Dentist:

.....

.....

Postcode:.....

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? Please circle
Snoring Yes / No; Sleep Apnoea Yes / No; Bruxism / Tooth Grinding Yes / No; Temperomandibular Jaw Joint (TMD) pain Yes / No

Do you snore?	Yes / No
If yes, please circle	quiet / loud / very loud / deafening
Do you have daytime sleepiness?	Yes / No
Shared or separate bedrooms?	shared / separate
Do you habitually sleep on your back?	Yes / No
Does your jaw fall open during sleep?	Yes / No
Do you have a dry mouth or throat in the morning?	Yes / No
Do you awake from sleep feeling choked?	Yes / No
Has anyone noticed you stop breathing whilst asleep?	Yes / No
Do you awake at night to pass water? How often?	Yes / No 1 2-3 4+
What time do you usually go to sleep?	
What time do you wake up?	
What is your collar size now?	
What was your collar size 5 years ago?	
What is your weight now?	
What was your weight 5 years ago?	

Do you have trouble breathing through your nose at night?	Yes / No
Weekly alcohol intake	Units:
Daily cigarette intake	Don't smoke / ..... per day

Please list any medical conditions:	**Or past operations:**

Do you have temperomandibular joint problems (TMD)? Yes / No
Do you suffer from tinnitus? Yes / No Do you have any allergies?

Please list any medications being taken:

Medication	**Dose**

Height (metres): ..... Weight (kilos): ..... BMI: ..... BP: ..... Epworth score: .....

Previous efforts to treat sleep disorder:

Conservative regimens (e.g. weight loss, exercise):.....
Mandibular advancement devices:.....
Nasal continuous positive airway pressure (CPAP):..... Surgery:.....
Previous sleep study: Yes/No when?.....where? .....(AHI).....

Snoring commonly follows partial closure of the airway, normally at the back of the throat, during sleep. However it may be accompanied by obstructive sleep apnoea (OSA) which is a more serious and potentially life threatening condition. This and other screening questionnaires are used to help identify patients at risk but are not a definitive diagnosis for OSA. The diagnosis of OSA would require you to undergo an overnight sleep study. Severe OSA should be managed within a multidisciplinary team led by a chest physician.

Dental jaw posturing appliances have been shown to be effective in the management of snoring and/or mild OSA. The treatment will not cure the condition but works by holding the jaw in a forward postured position. This leads to an improvement in the airway space. To work, the clinical instructions supplied must be followed, the appliances must be worn during sleep and if not worn, the symptoms will return.

The response to this treatment varies and no guarantee in improvement of your condition can be given. With time, the symptoms may return as the body changes and adapts. Following the initial fitting, excessive salivation and some slight changes in sensation are to be expected. The teeth, bite, facial muscles and jaw joints may feel different. This usually settles.

There is a risk that with long term use, there may be permanent tooth movements or permanent jaw changes. Reporting any problems, especially those listed in the appliance care document, attending the post treatment assessment and regular follow-ups are recommended.

A high standard of mouth care is essential and must be maintained otherwise the appliances could damage the teeth and supporting structures.

Patient Consent:

I understand the questions being asked and have given honest and accurate responses. It has been explained to me that I would need an overnight sleep study to conclusively diagnose obstructive sleep apnoea. I have read the information supplied and understand that the Somnowell appliance may help manage my condition.

Patient's name.....

Patient's signature..... Date.....

SOMNOWELL A Lifetime of Good Sleep.

Questionnaire for Sleeping Partner

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.

Please tick box if you DO NOT wish your answers to be shared with your sleeping partner. ☐

Your name:..... Partner's name: ..... Date:.....

1. Does your partner stop breathing during their sleep? Yes No

If they do, how many times a night does this happen?

1-10 11-20 more than 20 times

2. Is your partner very restless in their sleep? Yes No
3. Does your partner snore very loudly in their sleep? Yes No
4. Has the noise been so bad that you have to sleep in another room? Yes No
5. Has your partner's personality changed lately? Yes No

   If so, in what way?.....
6. Does your partner fall asleep during the day? Yes No
7. Has your partner ever fallen asleep when driving a vehicle? Yes No

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 fo each situation:

0=never doze, 1=slight chance of dozing, 2=moderate chance, 3=high chance of dozing

Situation	Chance of Dozing (circle answer)			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theatre or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Thanks for your assistance

Epworth Sleepiness Scale

Name:…… Today's Date:……

Your age (Yrs):…..…. Your Sex (Male = M, Female = F):…….…..

How likely are you to do e off or fall asleep in the following situations, 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

It is important that you answer each question as best you can.

Situation	Chance of Dozing (circle answer)			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g a theatre or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for few minutes in the traffic	0	1	2	3

Thank You For Your Cooperation