Anti-snoring Device Patient Questionnaire
Clinician to send a copy of this completed questionnaire with provided GP letter to the patient's GP

Consultation Date: …… / ……. /…….

Section one. Patient details.

Patient Name: ……

Address: ……

Postcode: ……

Telephone - home: …… **Telephone - mobile:** ……

Section two. Patient lifestyle and medical history.

Your weight ……

Your height ……

Date of birth ……day/ …….month /…….year

Neck measurement ……

Alcohol consumption. Please state the quantity and size of alcoholic drinks you consume per week ……

……

Smoking level. Please state the approximate number of cigarettes you consume per week.....

Do you have a history of any of the following conditions:

Heart problems	**Yes** ☐	**No** ☐
High blood pressure	**Yes** ☐	**No** ☐
Diabetes	**Yes** ☐	**No** ☐
Thyroid syndrome	**Yes** ☐	**No** ☐
Are you taking any prescribed medicines?	**Yes** ☐	**No** ☐

If you answered yes, please state which medicine and dose.....

.....

Have you previously been treated for a sleep disorder?

Yes ☐ **No** ☐

If yes please give full details of treatment……

.....

Section three. Clinical score and outcome. Please refer to GP letter for further information.

We recommend your patients complete an additional clinical questionnaire such as Epworth Sleepiness Scale, Berlin, S.T.O.P.B.A.N.G. or Flemons S.A.C.S. to help determine risk of Obstructive Sleep Apnoea. Please refer to the attached GP letter for the questionnaire scoring, outcomes and references for further information.

Type of Questionnaire completed……

Clinical score and outcome……

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Section four. Patient wellbeing and sleeping habits.

Have you ever felt sleepy whilst driving **Yes** ☐ **No** ☐

If yes, how often? Please tick one box only.

Never ☐
Hardly ever ☐
Sometimes ☐
Usually ☐

Have you ever nodded off whilst driving? **Yes** ☐ **No** ☐

Do you feel tired in the morning? **Yes** ☐ **No** ☐

Do you wake up in the morning with a headache? **Yes** ☐ **No** ☐

Do you have problems when concentrating for long periods of time?
Yes ☐ **No** ☐

Does sleep suddenly overcome you during the day, do you doze off unintentionally during the day?
Yes ☐ **No** ☐

Are breathing breaks observed during your sleep and do you gasp for air afterwards?
Yes ☐ **No** ☐

Do you feel pain in the area of your jaw joints (area of the ear)?
Yes ☐ **No** ☐

Do you feel any tension or strain in your cheek muscles in the morning (area at the side of your face)?

Yes ☐ **No** ☐

Section five. Partner feedback (if applicable).

Do you sleep in the same room as your partner?

Yes ☐ **No** ☐

Please indicate your quality of sleep.

Good ☐ **Average** ☐ **Poor** ☐

How would you rate the severity of your partner's snoring? Please tick one box only.

No snoring ☐ **Mild** ☐ **Moderate** ☐ **Loud** ☐ **Very Loud** ☐

How often does your partner's snoring disturb your sleep? Please tick one box only.

Never ☐ **Hardly ever** ☐ **Sometimes** ☐ **Usually** ☐ **Always** ☐

Does your partner only snore when laid on his/her back? **Yes** ☐ **No** ☐
Does your partner only snore when his/her mouth is open? **Yes** ☐ **No** ☐
Does your partner grind or clench his/her teeth during sleep? **Yes** ☐ **No** ☐

DISCLAIMER – This questionnaire is intended to give an overall indication of a patient's sleep health and snoring patterns. It is not intended for the diagnosis of Obstructive Sleep Apnoea. The responses from patients are subjective and have the potential to be understated. We recommend each questionnaire is copied and posted to the patient's GP as a matter of routine. An overnight sleep study is required in order to diagnose OSA.

To: From:

Date:

Dear Dr

RE: GP REFERRAL – SNORING AND/OR OBSTRUCTIVE SLEEP APNOEA PATIENT

Patient name:

We have provided the above patient with a Mandibular Advancement Device to manage their snoring.

We felt it important to alert you of this as many patients who snore are potentially at risk of Obstructive Sleep Apnoea.

Please refer to the attached questionnaire for further information. The patient has also completed one of the following recommended clinical questionnaires in order to support in assessing the risk of Obstructive Sleep Apnoea:

Type of Questionnaire completed:

Clinical score and outcome:

Please turn over for recommended questionnaires, overview of scoring guide and references for further information on each.

Further comments

If the patient is found to be of risk of OSA, it is recommended that further medical assessment takes place with a qualified Sleep Specialist. I would therefore be grateful if you could consider these results and refer to a specialist in sleep medicine if you feel that this is necessary. If you require any further information or assistance on this matter, please do not hesitate to get in touch.

Yours sincerely,

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Questionnaire scoring guides

Epworth Sleepiness Scale Questionnaire[1]

- **0-10 – Lower to higher normal daytime sleepiness……Low risk**
- **11-12 - Mild excessive daytime sleepiness……High risk**
- **13-15 - Moderate excessive daytime sleepiness……..High risk**
- **16-24 - Severe excessive daytime sleepiness……..High risk**

Berlin Questionnaire[2]

- **1 or no categories where the score is positive……Low risk**
- **2 or more categories where the score is positive……..High risk**

Flemons S.A.C.S. Questionnaire[2]

- **<15……Low risk**
- **≥15……..High risk**

S.T.O.P.B.A.N.G Questionnaire[2]

- **Female 0-4 yes score and BMI <35KG/M2……..Low risk**
- **Male and yes to 2 or more of 4 S.T.O.P. questions……..High risk**
- **BMI >35KG/M2 and yes to 2 or more of 4 S.T.O.P. questions……..High risk**

References for further information:

1. epworthsleepinessscale.com
2. http://www.seminmedpract.com/pdf/jcom_sep11_apnea.pdf, Sundar, E, Chang, J, and Smetana, G.W. (2011) "Perioperative Screening for and Management of Patients with Obstructive Sleep Apnea" *Journal of Clinical Outcomes Management,* Vol. 18, No. 9. pp 399 – 411.