JAEGER
ORTHODONTICS

Sleep Apnea Packet:

Please attached a copy of Drivers License and your Medical Insurance Card (front & back)

Patient Intake Form

Sleep Health History

Statement of Sleep Apnea Therapy

Epworth Scale

Copy of your Sleep Study Test from Sleep Doctor

JAEGER
ORTHODONTICS

Patient Intake

Date: _____

Patient Name:_____ Date of Birth:_____

Gender: M / F Home Phone:_____ Cell:_____ Work:_____

Address:_____

City:_____ State:_____ Zip:_____

Height:_____ Weight:_____ Neck Size:_____BMI:_____

Primary Care Physician:_____ Phone Number:_____

Type of Medical Insurance: Medicare HMO PPO Tricare Other N/A

Name of Insurance:_____ Member ID #:_____

Group #: Insurance Phone #

Have you been Diagnoses with the following?

Obstructive Sleep Apnea: Yes / No

Loud Snoring: Yes / No **High Blood pressure:** Yes / No **Heart disease:** Yes / No **Stroke:** Yes / No

Diabetes: Yes / No **Thyroid:** Yes / No **Insomnia:** Yes/ No **Depression:** Yes / No **COPD:** Yes / No

Morning Headache: Yes / No **Restless Leg Syndrome:** Yes / No **Night time Urination:** Yes / No

Epworth Sleepiness Questionnaire

Use the following scale to choose the most appropriate # for your situation.
0 = Never Doze 1 = Slight Chance 2 = Moderate Chance 3 = High Chance

Sitting and reading	**0**	**1**	**2**	**3**
Sitting quietly in a public place	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting quietly after lunch w/o alcohol	**0**	**1**	**2**	**3**
As a passenger in a car not stopping to stretch	**0**	**1**	**2**	**3**
In a car while stopped in traffic for a few minutes	**0**	**1**	**2**	**3**
Laying down to rest in the afternoon	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**

_____ **Total Score**

Sleep Health History

Patient Name: _____ DOB: _____

Associated Comorbidities

Hypertension *High Blood Pressure*	Y	N	Heart Disease	Y	N
			Mood Disorders	Y	N
History of Stroke	Y	N	Insomnia	Y	N
Type 2 Diabetes	Y	N	Impaired Cognition	Y	N

Epworth Sleepiness Scale

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	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	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total _____

Patient Signature: _____ Date: _____

Statement of Sleep Apnea Therapy

☐ **I have mild or moderate sleep apnea and per the American Academy of Sleep Medicine, CMS Guidelines and insurance policy, I would like to use oral appliance therapy as first line treatment.**

☐ **I am unable to use the nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following marked reason(s):**

- ☐ Mask Leaks
- ☐ An Inability 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 Sleep or Bed/Partner's Sleep
- ☐ CPAP Restricted Movements During Sleep
- ☐ Latex Allergy
- ☐ Claustrophobic Associations
- ☐ An Unconscious Need to Remove the CPAP Apparatus at Night
- ☐ I Would Like to Use Oral Appliance Therapy in Conjunction with CPAP Therapy to Reduce the CPAP Pressure.
- ☐ Other _____

Patient Full Name _____ Date of Birth _____

Patient Signature _____

Date _____

Epworth Scale

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name		Tally ARES Risk Points
Weight	Pounds	**Age**	Years	Gender: Male ○ Female ○	
Height	Feet / Inches		**Neck Size**	Inches	Neck Size +2 Male ≥16.5 +2 Female≥15.0
Date of Birth	Month / Day / Year		**ID Number**	Optional	Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

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

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score **TOTAL** the values from all 8 questions, If 11 or less **Score = 0** If 12 or more **Score = 2**

Score

Frequency **0 - 1 times/week** **1 - 2 times/week** **3 - 4 times/week** **5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Assign points for each of the first three responses

Signature	Area Code / Phone Number	**Total all 6 boxes from above** **If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)**	**Point Total**

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