PERIODONTAL MEDICINE
Surgical Specialists, LLC
Personalized | Preventative | Predictable | Proven

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PATIENT INFORMATION	
Patient Name	Date

AIRWAY QUESTIONNAIRE			
Daytime symptoms:		**Upper airway:**	
Frequent sickness (e.g. colds, flu)	☐Yes ☐No	Heightened gag reflex	☐Yes ☐No
Fatigue	☐Yes ☐No	Difficulty breathing at times	☐Yes ☐No
Morning headaches	☐Yes ☐No	Small nasal openings	☐Yes ☐No
Muscle aches, pains, soreness	☐Yes ☐No	Frequent sinus infections	☐Yes ☐No
Difficulty concentrating	☐Yes ☐No	Frequent sore throat	☐Yes ☐No
Need caffeine throughout the day	☐Yes ☐No	Known deviated septum	☐Yes ☐No
Frequent neck soreness	☐Yes ☐No	Post nasal drip	☐Yes ☐No
TMD pain (jaw joint)	☐Yes ☐No	Sinus/nasal congestion	☐Yes ☐No
Forgetfulness	☐Yes ☐No	Cough/throat clearing	☐Yes ☐No
		Migraines	☐Yes ☐No
Sleep Disturbances:		Known nasal polyps	☐Yes ☐No
Regular use of sleep aids	☐Yes ☐No	Halitosis (bad breath)	☐Yes ☐No
Frequent nightly awakenings	☐Yes ☐No	Frequent nosebleeds	☐Yes ☐No
Difficulty initiating sleep	☐Yes ☐No	Altered smell	☐Yes ☐No
Insomnia/difficulty maintaining sleep	☐Yes ☐No	Lip/chin strain to close mouth	☐Yes ☐No
Nighttime bathroom trips	☐Yes ☐No	Frequent runny nose	☐Yes ☐No
Teeth grinding, clenching	☐Yes ☐No	Nasal obstruction	☐Yes ☐No
Restless leg syndrome	☐Yes ☐No	Mouth breathing	☐Yes ☐No
GERD/acid reflux	☐Yes ☐No	Hypernasality (excessive breathing through nose/continual sniffles)	☐Yes ☐No
Snoring	☐Yes ☐No		
Light sleeper	☐Yes ☐No		
Dry mouth at night or awakening	☐Yes ☐No		
Chapped lips	☐Yes ☐No		
Sleep position ☐Back ☐Stomach ☐Side ☐Combo ☐Unknown		**Neck size** (typical: Male=17 in; Female=15 in)	

Functional somatic syndrome:	
Depression	☐Yes ☐No
Chronic fatigue syndrome	☐Yes ☐No
Irritable bowel syndrome	☐Yes ☐No
Fibromyalgia	☐Yes ☐No
Polysomatic disorder (known central sensitivity syndrome)	☐Yes ☐No
Mood swings/irritability	☐Yes ☐No
Anxiety/panic attacks	☐Yes ☐No
Autonomic nervous system:	
Hypotension (low blood pressure)	☐Yes ☐No
Orthostasis (lightheaded when standing up)	☐Yes ☐No
Cold hands and feet	☐Yes ☐No
Unexplained shaking at night	☐Yes ☐No
History of latent bed wetting	☐Yes ☐No
Night sweats	☐Yes ☐No
Orthodontic history:	
History of tooth (premolar) extractions	☐Yes ☐No
History of headgear	☐Yes ☐No
History of palatal expansion	☐Yes ☐No
History of functional appliances	☐Yes ☐No
History of orthodontic retreats	☐Yes ☐No
Most recent orthodontic treatment:	
Neurologic:	
Claustrophobia	☐Yes ☐No
Pill rolling (neurological repetitive motion such as twitching, hand rolling, rocking, or rolling pills in mouth)	☐Yes ☐No
Constipation	☐Yes ☐No
Tingling in hands	☐Yes ☐No
Off balance/tripping	☐Yes ☐No
Hand/arm hanging while walking	☐Yes ☐No
Nighttime drooling	☐Yes ☐No
Eczema	☐Yes ☐No
OCD (Obsessive Compulsive Disorder)	☐Yes ☐No
Low Ferritin levels	☐Yes ☐No

Reflux Symptom Index:	
How do the following problems affect you? 0 = No Problem 5 = Severe Problem	
Hoarseness or a problem with your voice ☐0 ☐1 ☐2 ☐3 ☐4 ☐5	
Clearing your throat ☐0 ☐1 ☐2 ☐3 ☐4 ☐5	
Excess throat mucous or postnasal drip ☐0 ☐1 ☐2 ☐3 ☐4 ☐5	
Difficulty swallowing food, liquids, or pills ☐0 ☐1 ☐2 ☐3 ☐4 ☐5	
Sensations of something sticking in your throat or a lump in your throat ☐0 ☐1 ☐2 ☐3 ☐4 ☐5	
Coughing after you eat or after lying down ☐0 ☐1 ☐2 ☐3 ☐4 ☐5	
Breathing difficulties of choking episodes ☐0 ☐1 ☐2 ☐3 ☐4 ☐5	
Troublesome or annoying cough ☐0 ☐1 ☐2 ☐3 ☐4 ☐5	
Heartburn, chest pain, indigestion, or stomach acid coming up ☐0 ☐1 ☐2 ☐3 ☐4 ☐5	
Reflex Symptom Index Total (add numbers above):	
Symptoms of LRP (Laryngopharyngeal reflux)	
Intermittent dypsonia (difficulty producing speech) ☐Yes ☐No ☐Maybe	
Sialorrhea (hypersalivation) ☐Yes ☐No ☐Maybe	
Cervical dysphagia (difficulty swallowing) ☐Yes ☐No ☐Maybe	
Dysgeusia (distorted sense of smell) ☐Yes ☐No ☐Maybe	
Halitosis (bad breath) ☐Yes ☐No ☐Maybe	
Throat pain ☐Yes ☐No ☐Maybe	

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FATIGUE SEVERITY SCALE (FSS)							
Select the number between 1 and 7 that you feel best fits the following statements. This refers to your usual way of life within the last week. **1 = "strongly disagree" and 7 = "strongly agree."**							
My motivation is lower when I am fatigued	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Exercise brings on my fatigue	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
I am easily fatigued	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Fatigue interferes with my physical functioning	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Fatigue causes frequent problems for me	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
My fatigue prevents sustained physical functioning	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Fatigue interferes with carrying out certain duties and responsibilities	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Fatigue is among my most disabling symptoms	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Fatigue interferes with my work, family, or social life	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐

VISUAL ANALOGUE FATIGUE SCALE (VAFS)										
Please mark the number which describes your global fatigue with **0 being worst and 10 being normal.**										
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐

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NASAL OBSTRUCTION SYMPTOM EVALUATION (NOSE) ASSESSMENT

To better understand the impact of nasal obstruction on your quality of life, please complete the following survey.

Over the past ONE MONTH, how much of a problem were the following conditions for you?

	Not a problem	Very mild problem	Moderate problem	Fairly bad problem	Severe problem
Nasal congestion or stuffiness	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
Nasal blockage or obstruction	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
Trouble breathing through my nose	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
Trouble sleeping	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
Unable to get enough air through my nose during exercise or exertion	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
					Total score =
					Total x5 =

Nasal obstruction severity classification:

Mild (5-25) | Moderate (30-50) | Severe (55-70) | Extreme (80-100)

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REFLUX SYMPTOM INDEX						
How much do the following problems affect you? **(0 = No Problem | 5 = Severe Problem)**						
Hoarseness or a problem with your voice	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Clearing your throat	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Excess throat mucous or postnasal drip	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Difficulty swallowing food, liquids, or pills	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Coughing after you eat or after lying down	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Breathing difficulties or choking episodes	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Troublesome or annoying cough	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Sensations of something sticking in your throat or a lump in your throat	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Heartburn, chest pain, indigestion or stomach acid coming up	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
					Reflux Symptom Index Total =	

SYMPTOMS OF LRP			
Intermittent dypsonia (difficulty producing speech)	☐ Yes	☐ No	☐ Maybe
Sialorrhea (hypersalivation)	☐ Yes	☐ No	☐ Maybe
Cervical dysphagia (difficulty swallowing)	☐ Yes	☐ No	☐ Maybe
Dysgeusia (distorted sense of smell)	☐ Yes	☐ No	☐ Maybe
Halitosis (bad breath)	☐ Yes	☐ No	☐ Maybe
Throat pain	☐ Yes	☐ No	☐ Maybe

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EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale can be used to assess daytime sleepiness. In the following situations, how likely are you to doze off or fall asleep, in contrast to just feeling 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. It is important that you answer each question as best as you can.**

	Would never doze or sleep	Slight chance of dozing or sleeping	Moderate chance of dozing or sleeping	High chance of dozing or sleeping
Sitting and reading	0 ☐	1 ☐	2 ☐	3 ☐
Watching TV	0 ☐	1 ☐	2 ☐	3 ☐
Sitting inactive in a public place	0 ☐	1 ☐	2 ☐	3 ☐
Being a passenger in a car for an hour	0 ☐	1 ☐	2 ☐	3 ☐
Lying down in the afternoon	0 ☐	1 ☐	2 ☐	3 ☐
Sitting and talking to someone	0 ☐	1 ☐	2 ☐	3 ☐
Sitting quietly after lunch (no alcohol)	0 ☐	1 ☐	2 ☐	3 ☐
Stopping for a few minutes in traffic while driving	0 ☐	1 ☐	2 ☐	3 ☐
			Total score =	

Understanding your score:
Normal range in healthy adults (0-10) | Mild sleepiness (11-14)
Moderate sleepiness (15-17) | Severe sleepiness (18 or higher)