apnea&breathing clinic

Patient Health Questionnaire

Patient Name:____ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.
Date of Birth _______________ Age ______________ SSN: __________________________
Referred By:____ ☐ DDS ☐ MD ☐ ENT ☐ DC ☐ Other:_______
Patient Address ____________________________________ City __________________ St ____ Zip________
Phone Number: Home ________________________ Cell __________________ Work ___________________
Email Address ______________________________________ Preferred to be contact by __________________
Emergency Contact __________________________________ Phone Number __________________________
Insurance Carrier: ___________________________________ ID#:____________________ Grp#: _________
Insurance Phone: ___________________________________ ☐PPO ☐HMO ☐ EPO ☐ Other: __________
Responsible Party (if other than patient) ____
Family Dentist _____________________________________ Address &/or Phone _______________________
Primary Care Physician ______________________________ Address &/or Phone _______________________

Personal History and Anatomy
Height ____________ Weight ___________ BMI _________ Neck Circumference _________
Alcohol consumption (number of drinks per week) ___________
Medication Allergies ____
Describe your reactions ____

Current Medications ☐ See attached list.
Please list all medications you take, the does and the reason for taking them. Included all over-the-counters medications, herb, supplements, vitamins, oils, etc.

Medication	Dosage	Reason for taking

Please Check **ALL** Symptoms and their occurrence:

____ Excessive Daytime Sleepiness
____ Frequent Heavy Snoring
____ Night-time choking spells
____ Feeling unrefreshed in morning
____ Headaches
____ Dry mouth when waking
____ Told you “stop breathing”
____ Chronic Sinusitis
____ Fatigue
____ Difficulty falling asleep
____ Gasping when waking
____ Morning Hoarseness
____ Clenching/Grinding
____ Facial/Jaw Pain
____ Jaw Locking
____ Jaw Joint Noises
____ Tossing/Turning
____ Swelling in ankles/feet
____ Kicking/Leg Jerking
____ Repeated awakenings during sleep
____ Disrupts the sleep of others
____ Irritability

Patient Signature: ____ Date: ____________________

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Sleepiness Evaluation
Epworth Scale- For the following situations, answer with one of the following numbers

0 = Would never doze   1= Slight chance of dozing   2= moderate chance of dozing   3= high chance of dozing

Situation	**Score**
Sitting and Reading	_____
Watching TV	_____
Sitting, inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in afternoon, when circumstance permit	_____
Sitting and talking to someone	_____
In a car, while stopped for a few minutes in traffic	_____

Total: _________

Sleep Conditions
Sleep Positions ☐ Side ☐ Back ☐ Stomach ☐ Varies
Waking during the night ☐ Yes ☐ No
Average hours of sleep per night ______
If so, how many times ______

Sleep Center Evaluation
Have you ever had a sleep test? ☐ Yes ☐ No
If Yes:
Sleep Center: ________________________ Sleep Physician:________________________ ☐ Lab ☐ HST
Sleep Study date:___________________ AHI:___________ REM AHI: ___________ RDI: ___________

Continuous Positive Airway Pressure device (CPAP) Intolerance

___ I have attempted to use /continue to use a PAP machine to manage my sleep related breathing disorder (apnea) and I find it intolerable to use on a regular basis for the following reasons:

- ☐ Refuse CPAP: please mark **all** that apply below
- ☐ An Inability to get the mask to fit properly
- ☐ Disturbed or interrupted sleep caused by the presence of the device
- ☐ Noise level from the device disturbing sleep or bed partner's sleep
- ☐ CPAP restricted movements during sleep
- ☐ Mask/Nasal Accessory leaking beyond comfort
- ☐ Discomfort caused by the straps and headgear
- ☐ Pressure on the upper lip causes tooth related problems
- ☐ Latex allergy
- ☐ Claustrophobic associations
- ☐ Other ____

Due to my intolerance / inability to use the CPAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Advancement Device

Patient Signature: ____ Date: ___________________

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Health/Medical History - Please circle all that apply. *Do you currently have or have you experienced the following:*

Yes	No	Anemia	Yes	No	Hemophilia
Yes	No	Anxiety	Yes	No	Hepatitis
Yes	No	Asthma	Yes	No	Hearing Impairment
Yes	No	Birth defects	Yes	No	History of substance abuse
Yes	No	Bleed easily	Yes	No	Hypoglycemia
Yes	No	Blood pressure problems	Yes	No	Hay fever
Yes	No	Bruising easily	Yes	No	Huntington's Disease
Yes	No	Cancer	Yes	No	Insomnia
Yes	No	Chemo or radiation	Yes	No	Irregular heartbeat
Yes	No	Chronic fatigue	Yes	No	Kidney disease
Yes	No	Cold hands and feet	Yes	No	Liver disease
Yes	No	Currently pregnant	Yes	No	Leukemia
Yes	No	Depression	Yes	No	Migraines
Yes	No	Diabetes	Yes	No	Meniere's Disease
Yes	No	Difficulty concentrating	Yes	No	Multiple Sclerosis
Yes	No	Difficulty breathing at night	Yes	No	Muscle aches
Yes	No	Dizziness	Yes	No	Muscle fatigue
Yes	No	Epilepsy	Yes	No	Muscle spasms
Yes	No	Excessive thirst	Yes	No	Muscle tremors
Yes	No	Emphysema	Yes	No	Neuralgia
Yes	No	Fainting	Yes	No	Osteoarthritis
Yes	No	Fibromyalgia	Yes	No	Osteoporosis
Yes	No	Fluid retention	Yes	No	Ovarian cysts
Yes	No	Frequent colds/flu	Yes	No	Parkinson's disease
Yes	No	Frequent cough	Yes	No	Poor circulation
Yes	No	Frequent ear infections	Yes	No	Psychiatric care
Yes	No	Frequent sore throat	Yes	No	Rheumatic fever
Yes	No	Glaucoma	Yes	No	Rheumatoid arthritis
Yes	No	Heart disease/heart attack	Yes	No	Recent weight gain
Yes	No	Heart murmur	Yes	No	Recent weight loss
Yes	No	Heart pacemaker	Yes	No	Sinus problems
Yes	No	Heart palpitations	Yes	No	Shortness of breath
Yes	No	Heart Valve replacement	Yes	No	Slow healing sores
Yes	No	Speech difficulties	Yes	No	Swollen, stiff, painful joints
Yes	No	Thyroid problems	Yes	No	Tuberculosis
Yes	No	Intestinal disorder	Yes	No	Nervous system disorder
Yes	No	Mitral valve prolapse	Yes	No	Stroke
Yes	No	Mouth Breathing	Yes	No	Prior Orthodontic
Yes	No	Memory loss	Yes	No	Skin disorder
Yes	No	Use of tobacco products			

Yes No Injury to: ☐ Head ☐ Neck ☐ Face ☐ Teeth Other: ________________

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Do you have a history of facial/jaw pain? Yes No
If yes, explain: ____

Do you have currently or experienced jaw locking opening/closing? Yes No
If yes, explain: ____

Do you have currently or experienced jaw joint noises? Yes No
If yes, explain: ____

Surgical History: *have you have had any of the following*

Yes	No	General anesthesia	Yes	No	Jaw joint surgery
Yes	No	Adenoids removed	Yes	No	Oral surgery
Yes	No	Tonsils removed	Yes	No	Wisdom teeth removed

Additional notes: Yes No
____
____
____

****Authorization to release information to the below listed referring and treating healthcare professionals:**

Doctor Name	Location	Phone

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc. to any referring or treating healthcare professional. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

I authorize Apnea & Breathing Clinic and its assigned agents to assess, diagnose and provide treatment. I release all agents of Apnea & Breathing Clinic from liability that could occur related to this treatment.

Patient Signature: ____ Date: ____________________

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