COMPREHENSIVE HEALTH QUESTIONNAIRE

The purpose of this questionnaire is to determine the nature of your health problem. It is very important to be as accurate as possible in answering. Your partner may be able to assist you.
***Please remember to write your name at the bottom of each following page.**

General Information:

(This information will become part of your medical record and will remain confidential.)

Patient Name: Date:

(First) (Middle) (Last)

Address:

(Street) (City) (State) (Zip)

Home Phone Work Phone:

Cell Phone: May we call you at work?

Email: Best way to reach you?

Date of Birth: Age: Sex: ◯ Male ◯ Female

Height: _____" Weight: _____lbs. Marital Status: ☐ Single ☐ Widowed ☐ Divorced ☐ Married/Partner

SSN: Occupation:

Emergency Contact: Relationship: Phone Number:

Referring Physician: Primary Care Physician:

Medical History

List current medical conditions for which you are being treated.

Diagnosis	Year	Treating Physician

List all hospitalizations and surgeries you have had. (*Please be thorough and include surgeries to remove your adenoids or tonsils, or hospitalizations for head injury, seizures or heart conditions.)*

Hospitalization/Surgery	Year	Treating Physician

List medications you are currently taking. (*Please include prescription and non-prescription medications of all types, including sleep and non-sleep related as well as supplemental oxygen.)*

Medication	Reason	Dosage	How often

Please list any allergies we should be aware of:

Health Questions *(Please answer the best you can)*

Are you unable to sleep in a flat position due to shortness of breath?	○ Yes	○ No
Do you have a family history of snoring or other sleep disorders?	○ Yes	○ No
If yes, please describe:		
Have you ever had a concussion, head injury or serious blow to the head?	○ Yes	○ No
Do you have spells or seizures?	○ Yes	○ No
Do you have high blood pressure?	○ Yes	○ No
Have you experienced a weight gain in the last year?	○ Yes	○ No
If yes, how much weight?		
Has your shirt collar size increase recently?	○ Yes	○ No
If yes, by how much?		
Do you smoke?	○ Yes	○ No
How many packs per day? How long have you smoked?		
Have you quit smoking?		
How many packs per day prior to quitting? How long did you smoke? Year quit?		
Do you drink alcohol?	○ Yes	○ No
If yes, please estimate the number of drinks per day. (beer, wine, or liquor)		
Do you drink caffeinated drinks?	○ Yes	○ No
If yes, please estimate the number of drinks per day. (sodas, coffee, or tea)		
(Female) Have you gone through menopause?	○ Yes	○ No
(Males) Have you experience any prostate issues? (i.e. Frequent urination)	○ Yes	○ No

Sleep Health Concerns & Habits

Describe your sleep problem(s) in your own words.

Describe how and when this problem began.

Describe any treatments you have received for your problem.

Has this been a continuous problem?	○ Seldom	○ Occasionally	○ Frequent	○ Constant	
How long has your sleep problem bothered you?	○ More than 2yrs.	○ 1-2 yrs.	○ Several Months	○ Last 3 Months	○ Within the month
What time do you usually go to bed?	Weekdays:		Weekends:		
What time do you usually wake up?	Weekdays:		Weekends:		

Patient Name: DOB: DOS:

How long does it take you to fall asleep?

If you awake in the middle of the night, how long are you typically awake for?

Which shift do you work? (Check all that apply): ◯ Day ◯ Evening ◯ Night

Sleep Questions	Never	Rarely	Often	Usually	Always
How often do you rotate shifts?	◯	◯	◯	◯	◯
Does your job require overnight travel?	◯	◯	◯	◯	◯
Do you drink alcohol after 6pm?	◯	◯	◯	◯	◯
Do you drink caffeinated beverages after 6pm?	◯	◯	◯	◯	◯
Do you suffer from a loss of libido?	◯	◯	◯	◯	◯
(Males) Have you experienced difficulties with sexual functions?	◯	◯	◯	◯	◯

Sleep Questions	Never	Rarely	Often	Usually	Always
(Females) Does your sleep problem vary according to the stage of your menstrual cycle?	◯	◯	◯	◯	◯
(Females) Have you gone through menopause or had a hysterectomy?		◯ Yes	◯ No		
Are you able to fall asleep and awaken on a daily, weekly basis according to your desired schedule?	◯	◯	◯	◯	◯
Do you nap during the day or evening?	◯	◯	◯	◯	◯
Do you feel refreshed after a typical night's sleep?	◯	◯	◯	◯	◯
Do you feel sleepy during the day even when you have slept all night?	◯	◯	◯	◯	◯
Do you feel refreshed after a short nap?	◯	◯	◯	◯	◯
Do you get sleepy while driving?	◯	◯	◯	◯	◯
Have you had an accident or near accident when driving, due to excessive sleepiness?	◯	◯	◯	◯	◯
Do you fall asleep when you want to stay awake (movies, theater, church, or watching television)?	◯	◯	◯	◯	◯
Are you able to fight off the excessive sleepiness?	◯	◯	◯	◯	◯
Do you have memory or concentration problems?	◯	◯	◯	◯	◯
Do you experience vivid dream-like scenes upon awakening or falling asleep?	◯	◯	◯	◯	◯
When you are angry or laugh, do you ever feel weak, as though you might fall?	◯	◯	◯	◯	◯
Are you ever unable to move or speak upon falling asleep or awakening?	◯	◯	◯	◯	◯
Do you have trouble falling asleep when you go to bed?	◯	◯	◯	◯	◯

Patient Name: DOB: DOS:

	Never	Rarely	Often	Usually	Always
When you try to fall asleep does your mind race with thoughts?	☐	☐	☐	☐	☐
When you try to fall asleep do you feel pain?	☐	☐	☐	☐	☐
Does pain ever wake you up, disrupt your sleep or keep you from going back to sleep?	☐	☐	☐	☐	☐
Are you a light sleeper, easily awakened?	☐	☐	☐	☐	☐
Is your sleep disrupted because of your bed partner or others in your household?	☐	☐	☐	☐	☐
Do you snore?	☐	☐	☐	☐	☐
Does your snoring stop for brief periods during sleep?	☐	☐	☐	☐	☐
Does your breathing sometimes stop during sleep?	☐	☐	☐	☐	☐
Is your bed partner disturbed by your snoring?	☐	☐	☐	☐	☐
Do you wake up choking or gasping for breath?	☐	☐	☐	☐	☐
Do you have night sweats?	☐	☐	☐	☐	☐
Do you have heartburn at night?	☐	☐	☐	☐	☐
Do you have a bitter bile taste in the back of your throat when you wake up (not "morning breath")?	☐	☐	☐	☐	☐
Do you have nasal / sinus congestion at night?	☐	☐	☐	☐	☐
Do you have morning headaches?	☐	☐	☐	☐	☐
Are you a restless sleeper, tossing and turning at night?	☐	☐	☐	☐	☐
Do you have a creeping or crawling sensation in your legs when you lie down to sleep?	☐	☐	☐	☐	☐
Do you experience any type of leg or back pain during the night?	☐	☐	☐	☐	☐
Do you wake up with sore or aching muscles or joints (including leg or back pain)?	☐	☐	☐	☐	☐
Do you grind or clench your teeth during sleep?	☐	☐	☐	☐	☐
Did you walk or talk in your sleep as a child or adolescent?	☐	☐	☐	☐	☐
Do you now walk or talk in your sleep?	☐	☐	☐	☐	☐
Do you have frightening dreams or nightmares?	☐	☐	☐	☐	☐
Do your dreams or nightmares awaken you?	☐	☐	☐	☐	☐
Do you wet your bed?	☐	☐	☐	☐	☐

Other Sleep Concerns:

Patient Name: DOB: DOS:

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Epworth Sleepiness Scale

Patient's Name: **Date:**

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling 'just tired'? This refers to your usual way of life at present and the recent past. Even if you have not done some of those things recently, try to work out how you would be affected. Use the following scale to choose the most appropriate number per situation:

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

Situation	***Chance of Dozing***
Sitting and reading	
Watching television	
Sitting, inactive in a public place (e.g. theatre, meeting)	
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	
Total Score	

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Revised 01/2020

INFORMED CONSENT FOR THE TREATMENT OF SLEEP-RELATED BREATHING DISORDERS WITH ORAL APPLIANCE THERAPY

Obstructive Sleep Apnea (OSA)

You have been diagnosed by your Physician as requiring treatment for a sleep-related breathing disorder, such as snoring and/or OSA. OSA may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels. This condition can increase your risk for excessive daytime sleepiness, driving and work-related accidents, high blood pressure, heart disease, stroke, diabetes, obesity, memory and learning problems, and depression.

What is Oral Appliance Therapy?

Oral appliance therapy (OAT) utilizes a custom-made, adjustable FDA cleared appliance specifically made to assist breathing by keeping the tongue and jaw in a forward position during sleeping hours. In order to derive the benefits of OAT, the oral appliance must always be worn when you sleep

Benefits of OAT

OAT has effectively treated many patients. However, there are no guarantees that it will be effective for you. Every patient's case is different, and there are many factors that influence the upper airway during sleep. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time, you may still experience symptoms related to your sleep-related breathing disorder. Additionally, durable medical equipment such as your oral appliance requires specific homecare, maintenance and periodic replacement.

Possible Risks, Side-Effects and Complications of OAT

With an oral appliance, some patients experience excessive drooling, difficulty swallowing (with appliance in place), sore jaws or teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth, and short-term bite changes. It is possible to experience dislodgement of dental restorations, such as fillings, crowns and dentures. Most of these side effects are minor and resolve quickly on their own or with minor adjustment of the appliance.

Long-term complications include bite changes that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once OAT is discontinued. These changes are likely to continue to worsen with continued use of the device.

It is mandatory for you to complete follow-up visits with the Dentist who provided your oral appliance to ensure proper fit and optimal positioning. If unusual symptoms or discomfort occur or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further. Follow-up assessments are necessary to assess your health and monitor your progress.

Once your oral appliance is in an optimal position, a post-adjustment assessment by your Physician is necessary to verify that the oral appliance is providing effective treatment.

Alternative Treatments for Sleep-Related Breathing Disorders

Other accepted treatments for sleep-related breathing disorders include positive airway pressure (PAP) therapy, various surgical and implant procedures, and positional therapy (which prevents patients from sleeping on their back instead on their side). The risks and benefits of these alternative treatments should be discussed with your Physician who diagnosed your condition and prescribed treatment.

It is your decision to choose OAT alone or in combination with other treatments to treat your sleep-related breathing disorder. However, none of these may be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to this office (address below), or to your Physician. Failure to treat sleep-related breathing disorders may increase the likelihood of significant medical complications and/or accidental injury.

Important Disclaimer: The AADSM Informed Consent form does not protect you from liability generally for malpractice or negligence in the performance of medical/dental services. The AADSM Informed Consent form is only a model or guideline as informed consent is governed by the statutes and case law of individual states where member's practice.

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Revised 03/2020

INFORMED CONSENT FOR THE TREATMENT OF SLEEP-RELATED BREATHING DISORDERS WITH ORAL APPLIANCE THERAPY

Patient's Privacy and Confidentiality

I acknowledge receipt of the office's privacy policies. This includes a summary of the HIPAA federal law and the applicable state laws.

Patient Obligations and Acknowledgements

- I understand the explanation of the proposed treatment. Further additional communication tools such as videos, pamphlets or articles may be available at my request.
- I have read this document in its entirety and have had an opportunity to ask questions. Each of my questions has been answered to my satisfaction. If I do not understand this document, I have been offered this document in a different language or have been offered a language interpreter. My family alone is not acceptable to be my interpreter.
- I agree that regularly scheduled follow-up appointments with my Dentist (oral appliance provider) are essential. These visits will attempt to minimize potential side effects and to maximize the likelihood of management of my OSA.
- I understand that I must schedule a post-adjustment assessment with my Physician to verify that the oral appliance is providing effective treatment.
- I will notify this office of any changes to the OAT, my teeth and my medical condition(s).
- I understand that I must maintain my oral appliance through regularly scheduled follow-up appointments with my general dentist and my oral appliance provider dentist, if not the same.
- I understand that if I discontinue OAT, I agree to inform and follow up with my Physician and Dentist (oral appliance provider).
- I understand that refusing to participate and cooperate as stated herein will put my health at risk.
- I consent to treatment with a custom-made, adjustable, FDA cleared oral appliance to be delivered and adjusted by my Dentist (oral appliance provider). I agree to follow all post-delivery and homecare instructions

Please sign and date this form below to confirm your agreement with the above statements. You will receive a copy of this document for your records, and it will be included in your patient records.

Patient Name (Print): _____ Date: _____

Patient Signature: _____

If patient is a minor, please sign as Parent or Legal Guardian

Parent or Legal Guardian Name (Print): _____ Date: _____

Signature: _____

Witness (Print): _____ Date: _____

Witness Signature: _____

Dentist Acknowledgement

Dentist (Print): _____ Date: _____

Dentist Signature: _____

Important Disclaimer: The AADSM Informed Consent form does not protect you from liability generally for malpractice or negligence in the performance of medical/dental services. The AADSM Informed Consent form is only a model or guideline as informed consent is governed by the statutes and case law of individual states where member's practice.

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Revised 03/2020

AFFIDAVIT FOR INTOLERANCE TO PAP

Patient Name: DOB:

Check the following that applies:

- ○ I have **NOT** attempted to use PAP to manage my sleep related breathing disorder (apnea) and feel it would be intolerable to use for the following reasons *(check all that apply below)*:
- ○ I **HAVE** attempted to use the PAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reasons *(check all that apply below)*:
  - Amount of time PAP was used:

Reasons for PAP Intolerance

- ☐ Mask leaks
- ☐ An inability to get the mask to fit properly
- ☐ Discomfort 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
- ☐ CPAP does not seem to be effective
- ☐ Pressure on the upper lip causes tooth related problems
- ☐ Latex allergy
- ☐ Claustrophobic associations
- ☐ An unconscious need to remove the PAP apparatus at night
- ☐ Other (Please describe):

Based on my intolerance/inability to use PAP, I wish to have the alternative treatment, oral appliance therapy (OAT).

Patient Signature: Date:

NON-DENTIST-OF-RECORD RELEASE FORM

I am seeking treatment with a sleep orthotic appliance only. I understand that I am not a dental patient-of-record with **Collin Emerick, DDS and Brandon Canfield, DDS**.

The importance of regular dental care has been explained to me and I understand that **Collin Emerick, DDS and Brandon Canfield, DDS** will not be responsible for providing my preventative or emergency dental needs. At this time, I choose to have my routine and necessary dental care completed in another office.

Patient Name (Please Print) _____

Patient Signature_____Date_____

Witness Name (Please Print) _____

Witness Signature_____Date_____

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www.sleeptreatmentoh.com

Ohio Sleep Treatment LLC

PATIENT COMMUNICATION CONSENT FORM

I agree to allow Ohio Sleep Treatment to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize Ohio Sleep Treatment to leave DETAILED messages for me when I am unavailable. I also understand that I have the right not to sign this agreement.

I authorize Ohio Sleep Treatment to leave detailed messages via these contact methods:

Home Phone ☐ **Cell Phone** ☐ **Work Phone** ☐

I authorize Ohio Sleep Treatment and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below.
I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

Name	**Relationship**	**Contact Information**

EMERGENCYCONTACT ONLY-

Name: _____ Phone: _____

In general, the HIPPA privacy rule gives individuals the right to request on uses and disclosures of their protected health information (PHI) the individual is also provided the right to request confidential communication.

By my signature below I acknowledge that I have read and understand the Guidelines to Patient Communication and information provided on this consent form. I understand the risk associated with the different methods of communication, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that Ohio Sleep Treatment may impose.

_____

Patient/Guardian Signature Printed Date

6500 Busch Blvd Suite 104 Columbus, OH 43229
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OHIO SLEEP TREATMENT LLC

Dental History Questionnaire

1. How would you describe your dental health? ◯ Excellent ◯ Good ◯ Fair ◯ Poor
2. Have you ever had teeth extracted? ◯ Yes ◯ No
3. Do you wear removable partials? ◯ Yes ◯ No
4. Do you wear removable dentures? ◯ Yes ◯ No
5. Have you ever worn braces (orthodontics)? ◯ Yes ◯ No
6. Does your TMJ (jaw joint) click or pop? ◯ Yes ◯ No
7. Have you had TMJ (jaw joint) surgery? ◯ Yes ◯ No
8. Have you ever had gum problems? ◯ Yes ◯ No
9. Do you have dry mouth? ◯ Yes ◯ No
10. Have you ever had an injury to you head, face neck or mouth? ◯ Yes ◯ No
11. Are you planning to have dental work done in the next year? ◯ Yes ◯ No
12. Do you clench or grind your teeth? ◯ Yes ◯ No

If you answered YES to any of the questions above, please indicate the question number and the reason you answered, briefly, below:

_____

_____

_____

_____

_____

_____

_____

Patient Name _____ Date _____

Signature _____ Date _____