Comprehensive Health Questionnaire

General Information

Legal Name: _____ Preferred Name: _____

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

Height: _____ inches Weight: _____ lbs.

Address: _____
(Street) (City) (State) (Zip)

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Email: _____

Best Way to Reach You: Phone Email Text

Marital Status: Single Widowed Divorced Married/Partner

Occupation: _____ How Long? _____

Emergency Contact: _____ Relationship: _____ Number: _____

Please use this space if you run out of room on the next page.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medical History

CURRENT MEDICAL CONDITIONS

Please list current medical conditions for which you are being treated.

Diagnosis Year Treating Physician

_____

_____

_____

_____

HOSPITALIZATIONS/SURGERIES

List all hospitalizations and surgeries you have had. Please be thorough and include surgeries to remove your adenoids, tonsils, and/or wisdom teeth. Hospitalizations to be considered would be head injury, seizures, strokes, or heart conditions

Hospitalizations/Surgeries Year Treating Physician

_____

_____

_____

_____

MEDICATIONS

Please include prescriptions and non-prescription medications of all types, including sleep and non-sleep related.

Medication	Reason	Medication	Reason
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

ALLERGIES

Please list any medical or drug allergies, excluding environmental

_____

_____

Health History

Please circle "Y" for yes, and "N" for No

High Blood Pressure……..……..Y N

Heart Disease……...……Y N

Stroke……..Y N

Pulmonary Hypertension……...…..Y N

Type 2 Diabetes……Y N

Mood Disorders (anxiety/depression)……..Y N

Impaired Cognition (memory/concentration) Y N

Insomnia……..……Y N

Narcotic Use……Y N

Family History of Sleep Apnea……Y N

(Females) Menopausal/Perimenopausal…...…Y N

(Males) Difficulty w/sexual function…….....Y N

Sleep History

Describe your sleep problem in your own words:

_____

_____

When did this begin?_____

_____

Have you received any treatment(s) for this problem(s)?

_____

_____

_____

_____

Have you completed a sleep study? Y N

Was it a Home Sleep Test or In-Lab Test? _____

If so, when? _____ (please provide an estimate if you aren't sure)

Who ordered it? _____ (please provide as much information if you are sure exactly who)

Describe your typical sleeping position. (back, side, stomach, move frequently, etc, if any physical limitations please elaborate):

_____

_____

Sleep Survey

Please circle the option that best suits your daily life when you aren't using any therapy for your sleep

Snoring

Never Rarely Occasionally Usually Always

Observed Apneas *(stop breathing during sleep/gasping upon waking)*

Never Rarely Occasionally Usually Always

Morning Headaches

Never Rarely Occasionally Usually Always

Frequent Nighttime Bathroom use *(2 or more times a night)*

Never Rarely Occasionally Usually Always

Bruxism/Teeth Grinding

Never Rarely Occasionally Usually Always

Nighttime heart burn *(Sometimes this presents as a bitter taste in the back of the throat upon awakening)*

Never Rarely Occasionally Usually Always

Nasal congestion at night

Never Rarely Occasionally Usually Always

Mouth breathing during sleep

Never Rarely Occasionally Usually Always

Mouth open upon waking

Never Rarely Occasionally Usually Always

Difficulty initiating sleep upon lying down for bed

Never Rarely Occasionally Usually Always

Light sleeper/easily awakening

Never Rarely Occasionally Usually Always

Your bedtime partner’s sleep is disturbed by your snoring

Never Rarely Occasionally Usually Always

Restless sleeper/tossing & turning

Never Rarely Occasionally Usually Always

Difficulty maintaining sleep/frequent awakenings

Never Rarely Occasionally Usually Always

Feel sleepy during the day even when slept all night

Never Rarely Occasionally Usually Always

Inappropriate napping (movies, church, in public)

Never Rarely Occasionally Usually Always

Sleepy while driving

Never Rarely Occasionally Usually Always

Job requires overnight travel

Never Rarely Occasionally Usually Always

Follow a strict sleep schedule

Never Rarely Occasionally Usually Always

I am able to recall my dreams

Never Rarely Occasionally Usually Always

Epworth Sleepiness Scale

Patient's Name: _____ Date: _____

How likely are you to doze off or fall asleep in the following situations.

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:	_____

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)*:**

Reasons I CANNOT or WILL NOT be able to tolerate PAP

☐ 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: _____

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:

_____

_____

_____

_____

_____

_____

_____

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, Sandra Pasquinelli, DDS, Anup Dadhania, DDS, and Brandon Canfield, DDS**.

The importance of regular dental care has been explained to me and I understand that **Collin Emerick, DDS, Sandra Pasquinelli, DDS, Anup Dadhania, 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 _____ Date _____

Signature _____ Date _____

Informed Consent for the Treatment of Sleep-Related Breathing Disorders With Oral Appliance Therapy

Obstructive Sleep Apnea

You have been diagnosed by your Physician as requiring treatment for a sleep-related breathing disorder (SRBD), such as snoring, Upper Airway Resistance Syndrome (UARS), and/or Obstructive Sleep Apnea (OSA). SRBDs 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 salivation, difficulty swallowing (with appliance in place), sore jaws or teeth, jaw joint pain, dry mouth, gum pain, 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 are typically progressive and may or may not be fully reversible once OAT is discontinued. 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 re-evaluation visit with your referring 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.

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 re-evaluation visit with my physician to verify that the oral appliance is providing effective treatment.
- I will notify this office of any changes to the oral appliance, my bite, my teeth, and my medical condition(s).
- 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 home care instructions.
- 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 understand that I must maintain my oral appliance and my oral health through regularly scheduled follow-up appointments with my general dentist and my oral appliance provider dentist, if not the same.

Please sign and date this form below to confirm your agreement with the above statements.

Patient Name (Print): _____ Date: _____

Patient Signature: _____

Witness Name (Print): _____ Date: _____

Witness Signature: _____

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

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

Parent or Legal Guardian Signature: _____

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SleepTreatmentOH.com

Privacy Policy Acknowledgement

Ohio Sleep Treatment follows all guidelines with your Personal Health Information (PHI) and will ONLY use that information as described in the 5 page "Notice of Privacy Practices". You may read through it if you request a copy. Please let us know if…

- You have any questions about this notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- You wish to obtain a form to exercise your individual rights.

Your Responsibilities:

- Provide accurate and complete information concerning your present medical conditions, past illnesses or hospitalization and any other matters concerning your health.
- Notify us if your insurance, address, phone number. etc. changes.
- Tell your provider(s) if you do not completely understand your plan of care.
- Follow the Providers' instructions.

My signature below indicates that I understand the Privacy Practices and my Responsibilities as a patient of Ohio Sleep Treatment.

Patient signature Printed name Date