Greenwich Sleep Apnea

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REGISTRATION FORM

PATIENT INFORMATION Date__ _____

Name_____ E-mail _____

Home Phone_____ Cell Phone_____ Work Phone_____

Address_____

City_____ State_____ Zip code_____

Date of Birth_____ Marital Status_____ Gender_____

Height_____ Weight_____ Occupation_____

Dental Insurance _____ ID_____

Primary holder _____ DOB of primary holder_____

How were you referred to our office? _____

Have you ever had a sleep study? YES / NO -if yes, please answer the questions below.

Where was your sleep study done? _____

Physician who requested the study? _____

Are you a current or past user of CPAP machine? YES / NO –if yes, how old is it?_____

Primary Care Physician_____

Dentist/Dental Specialist _____

MEDICAL HISTORY

For the following questions, circle **YES** or **NO**, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

YES NO 1. Are you generally in good health? _____

YES NO 2. Have there been any changes in your general health within the past year?

3. Last physical exam _____

YES NO 4. Are you now under the care of a physician?

If so, what is the condition being treated? _____

YES NO 5. Have you had any serious illness, operation, or been hospitalized in the past 5 years?

YES NO 6. Are you taking any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking? _____

YES NO 7. Do you have or have you had any of the follow disease or problems? Please circle.

a. Damaged heart valves, heart murmur, artificial valves, rheumatic heart disease, mitralvalve prolapse.

b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, High blood pressure, low blood pressure, arteriosclerosis) stroke.

YES NO 1. Do you have chest pain upon exertion?

YES NO 2. Are you ever short of breath after mild exercise or when lying down?

YES NO 3. Do your ankles swell?

YES NO 4. Do you have inborn heart defects?

YES NO 5. DO you have a cardiac pacemaker?

YES NO c. Allergy- seasonal, hay fever, sinus problems
YES NO d. Fainting spells, seizures, epilepsy, and neurological disease.
YES NO e. Persistent diarrhea or recent weight loss
YES NO f. Diabetes
YES NO g. Hepatitis, Jaundice or Liver disease
YES NO h. AIDS or HIV infection
YES NO i. Thyroid problems
YES NO j. Stomach ulcer or hyperacidity
YES NO k. Kidney trouble
YES NO l. Tuberculosis or persistent cough
YES NO m. Persistent swollen glands in neck
YES NO n. Sexually transmitted disease
YES NO o. Problems with mental health
YES NO p. Problems of the immune system
YES NO 8. Have you had abnormal bleeding or blood disorder?
YES NO a. Have you ever required a blood transfusion?
YES NO 9. Have you ever had any treatment for a tumor or growth?
YES NO 10. Have you had allergic reaction to?

a. Local anesthetics
b. Penicillin or other antibiotics_____
c. Aspirin
d. Codeine or other narcotics_____
e. Other_____

YES NO 11. Have you had any serious trouble associated with any previous dental treatment?
If so, explain: _____
YES NO 12. Do you have any disease, condition, or problem not listed above that we should know about? If so, explain_____
YES NO 13. Have you ever had Botox or filler? If so, explain:
_____

WOMEN PATIENTS ONLY

YES NO 14. Are you pregnant? How far along: _____
YES NO 15. Are you nursing?
YES NO 16. Are you taking birth control pills?

CPAP INTOLERANCE

If you have attempted treatment with a CPAP device, but could not tolerate it, please fill in this section:

- Mask leaks
- Disturbed or Interrupted sleep
- Noise disturbing sleep and/or bed partner's sleep
- CPAP does not seem to be effective
- Pressure on the upper lip causing tooth related problems
- Latex Allergy
- Claustrophobic associations
- An unconscious need to remove the CPAP
- Does not resolve symptoms
- Noisy
- Cumbersome

OTHER THERAPY ATTEMPTS

What other therapies have you had?

- Nasal Strips
- Positional therapy (side sleeping)
- Weight loss
- Surgery
- Pillar Procedure

SLEEP HISTORY

Previous Diagnosis

Have you previously been diagnosed with obstructive sleep apnea? _____

If yes, when was this: _____

Snoring was reported as, Frequency: _____Severity:_____

Sleep. How long does it take to fall asleep: _____ minutes

Normally go to bed at: _____

Hours you sleep per night: _____

Are you using a sleep aid: _____ Medication:_____

Do you suffer from:

- Bruxism
- Dry mouth
- Gasping
- Waking up and having difficulty returning to sleep

Frequency of nocturnal urination (#of times) _____

Thornton Snoring Scale

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her, both physically and emotionally. Use the following scale to choose the most appropriate number for each situation.

0 = Never
1 = Infrequently (1 night per week)
2 = Frequently (2-3 nights per week)
3 = Most of the time (4 or more nights per week)

My snoring affects my relationship with my partner: _____

My snoring causes my partner to be irritable or tired: _____

My snoring requires us to sleep in separate rooms: _____

My snoring affects people when I am sleeping away from home (hotels, camping, etc): _____

STOP-BANG Sleep Apnea Questionnaire	**Circle one**	
1. **S**noring		
Do you snore loudly? (Loud enough to be heard through closed doors)	YES	NO
2. **T**ired		
Do you often feel tired, fatigued, or sleepy during the day?	YES	NO
3. **O**bserved		
Has anyone ever observed you stop breathing during your sleep?	YES	NO
4. Blood **P**ressure		
Do you or are you being treated for high blood pressure?	YES	NO
5. **B**MI		
BMI more than 23kg/m2? (Obese)	YES	NO
6. **A**ge		
Are you over 50 years old?	YES	NO
7. **N**eck circumference		
For male, is your shirt collar 17 inches/43cm or larger?	YES	NO
For women, is your shirt collar 16 inches/ 41cm or larger?		
8. **G**ender		
Male?	YES	NO

High risk of OSA: Answering yes to three or more

Low risk of OSA: Answering yes to less than three items

Epsworth Evaluation

How likely are you to dose off or fall asleep in the following situations, in contrast to just feeling tired? Use the following scale to choose the most appropriate number for each situation.

Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g. theater or a meeting)	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 afternoon when circumstances permit	0	1	2	3
Sitting quietly after a lunch break	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3

TOTAL: _____

Please check all that apply.

- o Falls asleep instantly
- o Feeling tired all day
- o Wakes up to use the bathroom
- o Heart palpitations
- o Nighttime sweating
- o Poor concentration/memory problems
- o Low libido
- o Gasping at night or being told you do
- o Feels moody or irritable
- o Morning headache
- o Feels dizzy
- o Snoring
- o Recent weight gain in last 6 months
- o Hard to fall asleep or stay asleep
- o Not feeling refreshed upon waking
- o Dry mouth/primarily a mouth breather
- o Sour taste in your mouth while sleeping or upon waking
- o Shortness of breath

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction, I will not hold the doctor, or any other member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Name _____ Date _____

Signature_____