The SLEEP & TMJ Group

DATE: ____________________

HEALTH HISTORY

NAME ____ BIRTH DATE _________________ SEX: **M** **F**

Occupation ____________________ Single Married Divorced Widowed Significant other

Height: ______ft. ______ Weight: ________# Weight change: In past year #: ________ Gain Loss In past 5 yrs #: ________ Gain Loss

SLEEP HISTORY

Have you had an overnight sleep study? **Y** **N** Sleep Center ________________________ Study date __________

Have you been diagnosed with Obstructive Sleep Apnea (OSA)? **Y** **N** ____

OSA Diagnosis: Mild Mod Severe Diagnosing Sleep Physician ____

Most noticeable symptom related to your **OSA** ____

Favorite sleeping position(s) __________________________ Least favorite sleeping position(s) _______________________
(Left side, right side, back, stomach) (Left side, right side, back, stomach)

MEDICAL HISTORY

Please "x" any of the following that you now have or have had in the past:

- ☐Heart condition
- ☐Sinus problems
- ☐Head/neck injury
- ☐Snore
- ☐Smoke Quit? When?_____
- ☐High blood pressure
- ☐Chronic headaches
- ☐Whip lash injury
- ☐Gasp
- ☐Allergies/Hay fever
- ☐Have a pacemaker
- ☐Tonsillectomy
- ☐Jaw-joint pain
- ☐Asthma
- ☐Orthodontics (braces)
- ☐Respiratory condition
- ☐Nose Surgery
- ☐Grind your teeth
- ☐Weight gain
- ☐Use alcohol
- ☐Thyroid condition
- ☐Loss of memory
- ☐ Clench your teeth
- ☐ Hepatitis: A B C
- ☐ Arthritis RA OA
- ☐ Diabetes
- ☐ Hard to concentrate
- ☐ Mood disorder
- ☐ Acid reflux
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Sexually transmitted disease
- ☐ AIDS/HIV
- ☐ TIA
- ☐ Parkinson's disease
- ☐ Epilepsy/Seizure disorder
- ☐ Cancer Current?
- ☐ Impaired cognition
- ☐ Insomnia
- ☐ Alzheimer's/dementia

Please list any other health conditions/allergies that we should be aware of ____

____

Other Surgeries, etc: ____

____

List medications you are currently taking, dosages & reason for use (use separate sheet if more space required):

____

____

Are you planning any dental treatment or surgery? **Y** **N** If yes, describe: ____

Do you wear any removable dental appliances (night guard, orthodontic retainer, dentures, partials)? **Y** **N**

Please describe ____

________________________________ ____________________________________ ____________________

SIGNATURE **PRINTED NAME** **DATE**

CHIEF COMPLAINTS/TREAMENT HISTORY

What are the **chief complaints** for which you are seeking treatment?

☐ CPAP intolerance
☐ Gasping when waking up
☐ Difficulty falling asleep
☐ Night-time choking spells
☐ Fatigue
☐ Significant daytime drowsiness
☐ Frequent heavy snoring
☐ Sleepiness while driving
☐ Frequent heavy snoring which affects the sleep of others
☐ Witnessed apneic events
☐ Other (please write in) ____________________

Are you a **current** CPAP (Continuous Positive Air Pressure) user? **Y** **N** How long? ____________
If **yes**, what are the current CPAP settings? ____________ If **no**, did you ever try the CPAP? **Y** **N**

CPAP INTOLERANCE

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

☐ Mask leaks
☐ CPAP restricted movement during sleep
☐ Inability to get the mask to fit properly
☐ An unconscious need to remove the CPAP
☐ CPAP does not seem to be effective
☐ Does not resolve symptoms
☐ Discomfort from headgear
☐ Pressure on the upper lip causing tooth-related problems
☐ Latex allergy
☐ Disturbed or interrupted sleep
☐ Cumbersome
☐ Noise disturbing sleep and/or bed partner's sleep
☐ Claustrophobic associations
☐ Other ____________________

If you have not attempted treatment with a CPAP device, but would prefer to use an oral appliance, please fill in this section

☐ I'm worried that the mask, straps/headgear will cause discomfort
☐ I'm worried that the noise from the device will disturb me and/or my bed partner's sleep
☐ I'm worried that the device will restrict movement during sleep
☐ I have a latex allergy
☐ I suffer from claustrophobia
☐ I travel frequently and am worried that a CPAP device will be hard to use due to logistical concerns (electricity, distilled water, etc)
☐ Other: ____________________

OTHER THERAPY ATTEMPTS

☐ Dieting/weight loss
☐ BiPAP
☐ CPAP
☐ Pillar procedure
☐ Smoking cessation
☐ Surgery (Uvulectomy, uvuloplasty, UPPP, etc.)
☐ Positional therapy (pillows, tennis balls, Rematee, etc.)
☐ Other (please describe) ____________________

HISTORY OF TREATMENT

Practitioner's name	Specialty	Treatment	Date of Treatment

FAMILY HISTORY

Has any member of your family had
☐ Obstructive Sleep Apnea? Family member(s)____________________
☐ Cardiovascular/heart disease? Family member(s)____________________
☐ Stroke/TIA? Family member(s)____________________
☐ Diabetes? Family member(s) ____________________
☐ Asthma/pulmonary/respiratory? Family member(s) ____________________