Patient Intake Form

SLEEP SOLUTIONS NORTHWEST
CPAP Alternatives • Snoring • TMJ Pain

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL.

PERSONAL INFORMATION

Name: *(Last, First, M.I.)*		**Today's Date:**	/ /		
Address:		**Date of Birth:**	/ /	**Age:**	
		Phone (H):	( ) -	**Gender:**	☐ F
City/State/Zip:		**Phone (C):**	( ) -		☐ M
Email:		**Phone (W):**	( ) -		

Contact Method:	☐ Home Phone	☐ Work Phone	☐ Cell Phone (call)	☐ Cell Phone (text)	☐ Email
Contact Time:	☐ Early Morning	☐ Late Morning	☐ Mid-day	☐ Late Afternoon	☐ Evening
Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Widowed

Referred by:		**If not referred, how did you hear about us:**	

EMERGENCY CONTACT INFORMATION

Name:		**Relationship:**		**Phone:**	( ) -

EMPLOYMENT INFORMATION ☐ Retired

Employer:		**Phone:**	
Occupation:			

MEDICAL CONTACTS

General Dentist:		**City:**		**Phone:**	( ) -
Primary Physician:		**City:**		**Phone:**	( ) -
Sleep Physician:		**City:**		**Phone:**	( ) -
Sleep Facility:		**City:**		**Phone:**	( ) -

Sleep Study: *(Baseline)*	/ /	**Trial period of CPAP Attempted?**	☐ Y ☐ N

CHIEF COMPLAINT: SLEEP BREATHING DISORDERS, TMJ ISSUES, FACIAL PAIN

Chief Complaints (Sleep Apnea):

☐ **Section not applicable. I don't have any of these concerns**

☐ Wake myself up gasping or snorting	☐ Bed partner says I have pauses in breathing while I sleep
☐ Bed partner says I snore frequently	☐ Difficulty staying asleep
☐ Difficulty getting to sleep	☐ Excessively tired as the day progresses
☐ Wake up feeling tired/unrefreshed	☐ Unwilling to attempt CPAP
☐ Unable to use CPAP	☐ Wake up with neck pain
☐ Wake up with a headache	☐ Other (specify): _____
☐ Wake up with jaw muscle/facial pain	

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CHIEF COMPLAINT: SLEEP BREATHING DISORDERS, TMJ ISSUES, FACIAL PAIN (CONTINUED)		
Chief Complaints (TMJ/Facial Pain):	☐ **Section not applicable. I don't have any of these concerns**	
	☐ Pain in front of ear canals (jaw joint)	☐ Pain in temple area
	☐ Pain in jaw muscles (cheek area)	☐ Difficulty opening wide
	☐ Jaw pain/stiffness after chewing, talking or dental visits.	☐ Jaw gets 'stuck' or locks open or closed.
	☐ Current sounds in jaw joints (clicking)	☐ Current sounds in jaw joints (popping)
	☐ Current sounds in jaw joints (gritty sounds)	☐ I often have unexplained pain in my head, neck or face

In your own words, please share with us any additional information as it relates to your chief complaint

HISTORY OF PRESENT ILLNESS/CONDITION
Please explain the overall timeline and sequence of the condition that is bringing you in to see us, INCLUDING all the following: The general **TIMELINE**, from initial onset of any symptoms, to diagnosis, to treatment attempts, to your current situation. **DURATION**; How long have you been having concerns with this issue? **SEVERITY**; how much is it affecting your life? Mild, moderate or severe? **ASSOCIATED SYMPTOMS**; Fatigue? Excessive daytime sleepiness? "Foggy thinking"? Drowsy Driving? Work performance issues? Impotence? Night time tooth grinding? Extra trips to the bathroom at night? Muscle Pain? Neck Pain? Jaw Pain? Jaw Popping? Jaw Locking?

REVIEW OF SYSTEMS Check any/all that apply			
Allergies:	☐ **No known allergies**	☐ Seasonal Congestion	☐ Worse at night?
	☐ Nickel	☐ Other Metals	☐ Acrylics/Plastics
	☐ Latex	☐ Other (specify below):	
	Notes:		
Immune System:	☐ **No known issues**	☐ Fibromyalgia	☐ Chronic Fatigue Syndrome
	☐ HIV Positive	☐ Other (specify below):	☐ Sjogren's Syndrome
	Notes:		
Cardiovascular Cerebrovascular:	☐ **No known issues**	☐ Heart Attack (year: _____)	☐ Atrial Fibrillation/Irregular Heartbeat
	☐ Heart Disease	☐ Congestive Heart Failure	☐ Stroke (year: _____)
	Notes:		

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REVIEW OF SYSTEMS (CONTINUED) Check any/all that apply			
Ears, Nose, Mouth Throat (ENMT):	☐ **No known issues**	☐ Dry mouth	☐ Headaches
	☐ Ear Aches	☐ Sore throat	☐ Nasal Congestion ☐ Worse at night
	☐ Unrepaired tooth decay or fractures	☐ Missing teeth	☐ Bleeding gums
Endocrine:	☐ **No known issues**	☐ Excessive daytime urination	☐ Multiple nighttime bathroom trips
	☐ Diabetes		
Gastrointestinal:	☐ **No known issues**	☐ GERD	☐ Unexplained Vomiting
	☐ Difficulty Swallowing	☐ Painful Swallowing	☐ Heartburn
Musculoskeletal:	☐ **No known issues**	☐ Jaw/Muscle Pain (cheek or temples)	☐ Face Pain
	☐ Neck Pain	☐ TMJ pain (near ear canal)	
	Notes:		
Neurological:	☐ **No known issues**	☐ "Foggy Thinking"	☐ Alzheimer's/Dementia
	☐ Cognitive Decline	☐ Brain Tumor	☐ Short-Term Memory Issues
	☐ Seizure Disorder		
	Notes:		
Psychiatric:	☐ **No known issues**	☐ Anxiety	☐ Nervousness
	☐ Depression	☐ PTSD	☐ Bulimia
Respiratory:	☐ **No known issues**	☐ Cough	☐ Asthma
	☐ Shortness of breath	☐ Wheezing	☐ COPD

SURGICAL HISTORY Please list any significant past surgical procedures.		
Date of Surgery: (Approximate)	**Type of Surgery:**	**Notes:**
	☐ Palate/Throat/Uvula	
	☐ Sinus/Nasal	
	☐ Tonsils/Adenoids	
	☐ Head/Neck/Jaw	
	☐ Other:	
	☐ Other:	
	☐ Other:	
Please provide any additional information you feel appropriate as it relates to your surgical history		

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FAMILY MEDICAL HISTORY

Please indicate if this condition is in your family medical history, and if so, who it affects

Sleep Disorders	☐ Mother	☐ Father	☐ Brother	☐ Sister
Heart Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
Heart Attack	☐ Mother	☐ Father	☐ Brother	☐ Sister
Stroke/CVA	☐ Mother	☐ Father	☐ Brother	☐ Sister
High Blood Pressure	☐ Mother	☐ Father	☐ Brother	☐ Sister
Dementia/Alzheimer's	☐ Mother	☐ Father	☐ Brother	☐ Sister
'Foggy' short-term memory	☐ Mother	☐ Father	☐ Brother	☐ Sister

SOCIAL HISTORY

How often do you consume alcoholic beverages within 3 hours of bedtime?

☐ Rarely/never ☐ Occasionally ☐ Once or twice/week ☐ Several times/week ☐ Daily ☐ Social drinker

How often do you consume caffeinated beverages within 3 hours of bedtime?

☐ Rarely/never ☐ Occasionally ☐ Once or twice/week ☐ Several times/week ☐ Daily

How often do you take sedatives or sleep aids (Rx or OTC) to help you fall or stay asleep?

☐ Rarely/never ☐ Occasionally ☐ Once or twice/week ☐ Several times/week ☐ Daily ☐ Daily – Melatonin

☐ Daily – Tylenol PM ☐ Daily – Trazodone ☐ Daily – Other: _____

How often do you smoke or use Nicotine containing products, including 'vaping' and Rx patches?

☐ Never smoked or use tobacco products ☐ Previously smoked/used tobacco products

☐ Currently smoke Packs per day: _____ ☐ Currently use Rx nicotine patches

☐ Currently use chewing tobacco ☐ Currently using smokeless tobacco (electronic cigarette)

Recreational drug usage ☐ No comment, prefer not to answer

☐ No history ☐ Stimulants_____

☐ Marijuana ☐ Currently use occasionally ☐ Currently use daily

Please provide any additional information you feel appropriate as it relates to your social history

MEDICATIONS

Please list all Prescription and OTC medications taken for the following conditions, if none, simply select "Not currently taking any medications"
***Please Note**: Medications used to treat mood disorders, depression, anxiety and the 'statins' used to treat high cholesterol CAN, in some cases, increase your tendency toward jaw clenching, grinding and muscle soreness/pain, with or without the use of a Mandibular Advancement Device.

Medications:	☐ **Not currently taking any medications**	
	Heart/Vascular Disease:	
	High Blood Pressure:	
	Depression/Anxiety/Mood Disorders:	
	High Cholesterol:	
	Other Medications & Conditions:	

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PERSONAL DENTAL HISTORY

Have you ever had a significant injury to your head, face, neck, or mouth?			☐ No	☐ Yes		
If yes, please provide details:						
What is the current health of your teeth & gums?			☐ Excellent	☐ Good	☐ Fair	☐ Poor
Have you ever had permanent teeth extracted?	☐ Wisdom Teeth	☐ No	☐ Yes		☐ Additional Teeth	
Do you wear full dentures?		☐ No	☐ Yes	☐ Upper	☐ Lower	☐ Both
If you wear a denture, is it supported by dental implants?		☐ No	☐ Yes	☐ Upper	☐ Lower	☐ Both
Do you wear a removeable partial denture?		☐ No	☐ Yes	☐ Upper	☐ Lower	☐ Both
Upcoming plans for implants, new crowns or bridges?		☐ No	☐ Yes			
If yes, what type of treatment and where?						
Have you ever worn orthodontic braces?		☐ No	☐ Yes			
Age when orthodontic braces completed?						
Do you have a dry mouth due to medications and/or a medical condition?		☐ No	☐ Yes			

Please provide any additional information you feel appropriate as it relates to your personal dental history

PERSONAL DENTAL HISTORY – JAW MUSCLES/JOINTS

Do you grind your teeth? (can cause excess tooth wear and jaw muscle pain)		☐ No	☐ Yes		
Do you clench your teeth? (can cause tooth cracks, fractures and jaw joint pain)		☐ No	☐ Yes		
If yes, do you wear a dental nightguard for it?		☐ No	☐ Yes		
Do you have limited ability to open?		☐ No	☐ Yes		
Does your jaw ever Lock?		☐ No	☐ Yes		
If yes, when and how often?	☐ Locks closed ☐ Locks open	☐ Rarely	☐ Once a month	☐ Several times/week	
Is it painful to open and close your mouth?		☐ No	☐ Yes		
If yes, where; jaw joint, muscles or both?		☐ Jaw Joint	☐ Muscles	☐ Both	

Please provide any additional information you feel appropriate as it relates to your personal dental history – jaw muscles/joints

PERSONAL DENTAL HISTORY – GUMS

Have you been told that you have gum disease (periodontitis)?		☐ Yes	☐ No	
If yes, approx. date treated?				
If yes, how was it treated?	☐ No treatment	☐ Root planing/scaling with local anesthetic		☐ Gum Surgery
How often to you receive a professional teeth cleaning?				
☐ Every 3-4 months	☐ Every 6-8 months	☐ Annually	☐ Every few years	☐ Never
Approximate date of last cleaning?				

Please provide any additional information you feel appropriate as it relates to your personal dental history – gums

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SLEEP HISTORY				
How long have you been experiencing snoring, excessive daytime sleepiness or other issues that led you to seek medical care for this issue?				
Have you ever had an at–home or in–hospital sleep study?	☐ Yes	☐ No		
If yes, approximate date of study?	/ /			
If yes, what were you told your diagnosis was? (check one)	☐ Normal	☐ Snoring ONLY	☐ Obstructive Sleep Apnea	
What treatment options were you offered?	☐ CPAP	☐ Weight Loss	☐ Dental Device	☐ Surgery
Do you work swing-shift or nighttime shifts?	☐ Yes	☐ No		
Does your shift/schedule change?	☐ Yes	☐ No		

Do you currently have any of the following Sleep Apnea related medical conditions?

☐ High Blood Pressure	☐ History of Stroke	☐ Impaired or 'Foggy' Thinking
☐ History of Heart Disease	☐ Depression/Anxiety/Mood Disorder	☐ Insomnia (initiate/maintain sleep)
☐ History of Heart Attack	☐ Excessive daytime sleepiness	

Have you ever tried any of the following to improve your sleep breathing disorder?

☐ CPAP	☐ Side Sleeping	☐ Surgical Treatments
☐ Weight loss	☐ Side Sleep Cushion	☐ Dental Device
☐ Nasal Strips or Inserts		

Please provide any additional information you feel appropriate as it relates to your personal sleep history

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Epworth Sleepiness Scale

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How likely are you to doze off in the following circumstances?

Many people subconsciously underestimate their symptoms. Please be as honest and accurate as possible. If "in between" numbers, round up.

Totals of 10+ may indicate sleep breathing issues that meet criteria for "medical necessity" for insurance coverage of sleep apnea.

0 – I would NEVER doze, 1 – Slight chance of dozing, 2 – Moderate chance of dozing, 3 – High chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting and talking to someone	_____
Sitting inactive in a public place (e.g.: a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting quietly after a lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
Total:	_____

I give my consent for an initial evaluation exam to determine my suitability for treatment my OSA or TMJ pain with a Dental Device. I agree and consent to allow Dr. Stuart Rich and team to examine my mouth, teeth, jaws, gums, and associated structures. I give consent for the taking of x-rays, photos and any other procedures necessary to determine if I am an appropriate candidate. I also give consent for the contents of my record to be shared with my health care provider and insurance company.

X _____ _____

Signature of Patient or Legal Guardian | Date

For Official Use Only:

Reviewed by: _____ Date: _____

I have personally reviewed this document in detail in a face to face encounter with this patient, and have made annotations where appropriate. This document to be considered part of the clinical record for the initial encounter and all subsequent encounters, provided it has been reviewed and any changes documented during future encounters.

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Affidavit for Intolerance to Positive Airway Pressure (PAP) Device

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I have attempted to use Positive Air Pressure CPAP, APAP, etc. to manage my Obstructive Sleep Apnea and find it intolerable to use on a regular basis for the following reason(s): **(Check all that apply)**

- ☐ Mask Leaks
- ☐ An inability to get mask to fit properly
- ☐ Discomfort caused by the straps and headgear
- ☐ Disturbed or interrupted sleep caused by the presence of device
- ☐ Noise from the device disturbing sleep or bed partner's sleep
- ☐ CPAP restricts movements during sleep
- ☐ CPAP does not seem to be effective
- ☐ Pressure on upper lip causes tooth-related problems
- ☐ Latex allergy
- ☐ Claustrophobic associations
- ☐ An unconscious need to remove the CPAP apparatus at night
- ☐ Other: _____

I have not attempted to use CPAP (Continuous Positive Air Pressure) device and would prefer to use an oral appliance for the following reason(s): **(Check all that apply)**

- ☐ I'm worried that mask, straps/headgear will cause discomfort
- ☐ I'm worried that 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 worried that a CPAP device will be cumbersome to transport
- ☐ Other: _____

Because of my inability to use a CPAP device, I wish to have an alternative method of treatment. I would like to try an oral appliance to control my snoring and obstructive sleep apnea.

X _____ _____

Signature of Patient or Legal Guardian | Date

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Acknowledgement of Receipt of Notice of Privacy Practices

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Notice of Privacy Practices Acknowledgement:

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I have been offered your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices, or print it from the practice website, www.SleepSolutionsNW.com.

Patient Name (Print): _____ Relationship: _____

X _____ _____

Signature of Patient or Legal Guardian | Date

Additional Disclosure Authority:

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected heath care information to the persons indicated below.

Spouse only:	☐ Yes	☐ No
Any member of my immediate family:	☐ Yes	☐ No
Other (please specify): _____	☐ Yes	☐ No

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