Sleep Better Austin Treatment, PLLC

New Patient Questionnaire

Patient Information

Patient First & Last Name: Date of Birth:

Today's Date:

Primary Care Provider & Referral

Primary Care Provider Name: Phone:

Referring Provider Name: Phone:

Do you currently see any other healthcare specialists (e.g., cardiologist, psychiatrist)? ☐ Yes ☐ No

If yes, check all that apply and provide name & phone number for each:

☐ Cardiologist: Phone:

☐ Dermatologist: Phone:

☐ Gastroenterologist: Phone:

☐ Ophthalmologist: Phone:

Other specialist:

Name: Phone:

Reason for Visit

Please list the main reason(s) you are seeking treatment for snoring or sleep apnea:

Symptoms — Do you have any of the following complaints?

☐ Frequent snoring
☐ Excessive daytime sleepiness
☐ Difficulty falling asleep
☐ Difficulty maintaining sleep (staying asleep)
☐ Waking up gasping / choking
☐ I have been told I stop breathing when I sleep
☐ Choking while sleeping
☐ Morning headaches
☐ Neck or facial pain
☐ Feeling unrefreshed in the morning
☐ Memory problems
☐ Impotence
☐ Nasal problems / difficulty breathing through nose
☐ Irritability or mood swings
☐ Other:

Subjective Signs and Symptoms

Rate your overall energy level (1 = Low, 10 = Excellent):

Rate your sleep quality (1 = Low, 10 = Excellent):

Have you been told that you snore? ☐ Yes ☐ No ☐ Sometimes

Rate the loudness of your snoring (1 = Quiet, 10 = Loud):

On average, how many times per night do you wake up?

On average, how many hours of sleep do you get per night?

How often do you wake up with a headache? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Everyday

Do you have a bed partner? ☐ Yes ☐ No ☐ Sometimes

Do you sleep in the same room as your partner? ☐ Yes ☐ No

How many times per night does your bed partner notice you stop breathing?

Frequency: ☐ Several/night ☐ Once/night ☐ Several/week ☐ Occasionally ☐ Seldom ☐ Never

Epworth Sleepiness Scale

For each situation, rate your usual chance of dozing (not just feeling tired): 0 = No chance of dozing, 1 = Slight chance, 2 = Moderate chance, 3 = High chance of dozing.

Sitting and reading

Watching TV

Sitting inactive in a public place (e.g., theater)

As a car passenger for an hour without a break

Lying down in the afternoon to rest

Sitting and talking to someone

Sitting quietly after lunch without alcohol

In a car while stopped for a few minutes in traffic

EPWORTH TOTAL SCORE:

Thornton Snoring Scale

Rate each item: 0 = Never, 1 = 1 night/week, 2 = 2–3 nights/week, 3 = 4+ nights/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 is loud

My snoring affects people when I am sleeping away from home

THORNTON TOTAL SCORE:

Nasal Obstruction Symptom Evaluation (N.O.S.E.) Score

Over the past 4 weeks, rate each: 0 = Not a problem, 1 = Very mild, 2 = Moderate, 3 = Fairly bad, 4 = Severe problem.

Nasal congestion or stuffiness

Trouble breathing through your nose

Unable to get enough air through your nose during exercise or exertion

Patient Name: DOB: Today's Date:

Nasal blockage or obstruction

Trouble sleeping

SYMPTOMS SCORE (total of above):

TOTAL N.O.S.E. SCORE (symptoms score × 5):

Sleep Study & CPAP History

Have you ever had a sleep study? ☐ Yes ☐ No

If yes, where was it performed? Date:

Have you tried CPAP? ☐ Yes ☐ No

Are you currently using CPAP? ☐ Yes ☐ No

If yes, nights worn per week: Hours worn per night:

If you use or have used CPAP, what are your chief complaints about it? (check all that apply)

- ☐ Mask leaks
- ☐ Inability to get the mask to fit properly
- ☐ Discomfort from straps or interrupted sleep
- ☐ Noise disrupting sleep / partner's sleep
- ☐ CPAP restricted movement during sleep
- ☐ CPAP seems to be ineffective
- ☐ Device causes teeth or jaw problems
- ☐ A latex allergy
- ☐ Causes claustrophobia or panic attacks
- ☐ Unconscious need to remove CPAP at night
- ☐ Causes GI / stomach / intestinal problems
- ☐ Irritates nasal passages
- ☐ Inability to wear due to nasal problems
- ☐ Causes dry nose or dry mouth
- ☐ Irritation due to air leaks
- ☐ Other:

Oral Appliance (Dental Device) History

Are you currently wearing an oral/dental device for sleep apnea, snoring, or teeth grinding? ☐ Yes ☐ No

If currently using one, who fabricated it?

Was your current/last device bought over-the-counter (no prescription)? ☐ Yes ☐ No

Have you previously tried a different dental device? ☐ Yes ☐ No

Please describe your dental device experience (fit, comfort, effect on bite, etc.):

Surgical History

Have you ever had surgery for snoring or sleep apnea? ☐ Yes ☐ No

Have you ever had any nose, roof of mouth, throat, tongue, sinus, or jaw surgery? ☐ Yes ☐ No

List any nose / palatal / throat / tongue / jaw surgeries:

Date	Surgeon	Surgery

- [ ] Tumor removal
- [ ] Hernia repair
- [ ] Other surgery/procedure:

If tumor removal: type, body location, and approximate date:

Tumor Type	Body Location	Date

If hernia repair, approximate date:

Please comment on any other therapy attempts (weight loss, gastric bypass, etc.) and how each affected your snoring, apnea, or sleep quality:

Medical History

Do you have, or have you ever had, any of the following? (check all that apply)

- [ ] Heart problems
- [ ] Stomach or intestine problems
- [ ] High blood pressure
- [ ] Joint problems
- [ ] High cholesterol
- [ ] Other:

If heart problems, which type(s)?

- [ ] Heart attack
- [ ] Irregular heartbeat
- [ ] Blockages
- [ ] Valve problems
- [ ] Other:

If stomach or intestine problems, which type(s)?

- [ ] Heartburn / GERD
- [ ] Irritable bowel syndrome
- [ ] Stomach ulcer
- [ ] Other:

If joint problems, which type(s)?

- [ ] Arthritis
- [ ] Degenerative joint disease
- [ ] Osteoporosis
- [ ] Other:

Please list any additional medical diagnoses and surgeries from birth until now:

Medications

Are you currently taking any medications (prescription, non-prescription, or herbal supplements)? ☐ Yes ☐ No

List all medications, dosage, and how often you take them:

Medication	Dosage	Frequency

Allergies

Have you ever had an allergic reaction to anything (medication, latex, suture material, etc.)? ☐ Yes ☐ No

List each allergen and the reaction experienced:

Allergen	Reaction

Dental History

How would you describe your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever had a tooth extracted? ☐ Yes ☐ No Describe:

Do you wear removable partials? ☐ Yes ☐ No

Do you wear full dentures? ☐ Yes ☐ No

Have you ever worn braces (orthodontics)? ☐ Yes ☐ No Date completed:

Does your jaw joint (TMJ) click or pop? ☐ Yes ☐ No

Do you have pain in that joint? ☐ Yes ☐ No

Have you ever had TMJ (jaw joint) surgery? ☐ Yes ☐ No

Have you ever had gum problems? ☐ Yes ☐ No

Have you ever had gum surgery? ☐ Yes ☐ No

Do you have dry mouth? ☐ Yes ☐ No

Have you ever had an injury to your head, face, neck, or mouth? ☐ Yes ☐ No

Are you planning to have dental work done in the near future? ☐ Yes ☐ No

Do you clench or grind your teeth (bruxism)? ☐ Yes ☐ No

If you answered yes to any dental history question above, briefly describe:

Current Dentist Name:

Is there anything else about your dental health we should know?

Family History

Have any genetic (blood relative) family members had or been treated for the following?

Heart disease ☐ Yes ☐ No

High blood pressure ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

A sleep disorder ☐ Yes ☐ No

Social History

How often do you drink alcohol within 2–3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

How often do you take sedatives within 2–3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

How often do you consume caffeine within 2–3 hours of bedtime? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

Do you smoke or use tobacco? ☐ Yes ☐ No Packs/day:

Do you use chewing tobacco? ☐ Yes ☐ No Times/day:

Pre-Medication

Have you been told you should receive pre-medication before dental procedures? ☐ Yes ☐ No

If yes, what medication(s) and why do you require it?

Medical Insurance Information

Subscriber's Name:

Subscriber's Date of Birth: Member ID / Identification Number:

Missed Appointment Consent

We respectfully ask that you give us 48 HOURS notice if you are unable to make your appointment so that we may reschedule as soon as possible to best accommodate all of our patients' scheduling needs. A “missed” appointment is one that is not kept, canceled, or rescheduled without at least 48 hours notice. We will ask you to place a credit card on file for these instances; you will NOT be charged for anything unless you are fully aware of the charge. If you feel your card has been wrongfully charged, please contact our office as soon as possible.

If you miss an appointment, you will be charged a fee of $50.00.

I have read and understand the missed appointment policy set forth by Sleep Better Austin and agree to abide by it. By signing below, I indicate and accept responsibility for any charges incurred as described in the missed appointment policy above.

Patient Signature: Date:

HIPAA Consent

Patient Name (print):

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: Date:

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient:

REVOCATION OF CONSENT (sign only if applicable): I revoke my consent for use and disclosure of my protected health information for treatment, payment activities, and health care operations. I understand revocation will not affect any action taken in reliance on my consent before this written notice was received, and that Sleep Better Austin may decline to treat or continue treating me after I have revoked my consent.

Signature: Date: