CHIEF COMPLAINT

Name: ______________________________ DOB: ______________________________

Current date: ________________________

Please answer the questions below:

What are the chief complaints for which you are seeking treatment
Number the complaints with #1 being the most important.

_________ Frequent heavy snoring which affects the sleep of others

_________ Daytime sleepiness

_________ I have been told that I stop breathing

_________ I have trouble falling asleep

_________ Gasping when I wake up

_________ Nighttime choking spells

_________ I feel unrefreshed in the morning

_________ My throat is hoarse in the morning

_________ I frequently have morning headaches

_________ I have swelling in my ankles and/or feet

_________ I grind my teeth

_________ My jaw clicks

_________ Other _________________________

CPAP INTOLERANCE FORM

I have attempted to use the CPAP machine to manage my Obstructive Sleep Apnea but find it intolerable for the following reasons (please check all that apply):

☐ I find the device cumbersome and it interrupts my sleep

☐ The machine is noisy and negatively impacts my sleep or my bed partner's sleep

☐ I am unable to sleep on my back like the CPAP requires

☐ I am unable to tell a noticeable difference in my symptoms of sleep apnea when I wear the machine

☐ The pressure on my machine is too high

☐ I remove my CPAP unknowingly when I am sleeping

☐ I feel claustrophobic when I wear the mask

☐ I have been unable to find a mask that fits properly

☐ The mask leaks

☐ The straps or headgear cause me discomfort

☐ I refuse to even attempt CPAP

☐ If other, please explain: ____

____

____

I have found that I am unable to comply with the CPAP machine as a treatment for my Sleep Apnea. For this reason, I am seeking an alternative treatment method for my condition. I realize that the treatments I am consenting to may help my sleep apnea, but may not completely alleviate it (particularly if my sleep apnea is severe). My physician has advised me of alternative therapies that may be used in conjunction with the treatments I am consenting to today.

____
Patient Name

____
Date

____
Patient Signature

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Patient Name: ____________________

MEDICAL HISTORY

Are you allergic to any medication? If yes, please list below along with a description of the reaction you experienced.

____

____

____

Are there any medications that you are currently taking including over the counter medicines and vitamins?
If yes, please list.

____

____

____

Do you have a history of any of the following medical conditions? Please circle.

Condition	Y / N
Anemia	Y / N
Arteriosclerosis	Y / N
Asthma	Y / N
Autoimmune disorders	Y / N
Bleeding	Y / N
Chronic sinus issues	Y / N
Chronic fatigue	Y / N
Congestive heart failure	Y / N
Current pregnancy	Y / N
Diabetes	Y / N
Difficulty concentrating	Y / N
Dizziness	Y / N
Emphysema	Y / N
Epilepsy	Y / N
Fibromyalgia	Y / N
Frequent sore throats	Y / N
Gastroesophageal Reflux (GERD)	Y / N
Hay fever	Y / N
Heart disorder	Y / N
Heart murmur	Y / N
Heart pacemaker	Y / N
Hepatitis	Y / N
Hypertension	Y / N
Immune system disorder	Y / N
Insomnia	Y / N
Jaw joint surgery	Y / N
Memory loss	Y / N
Morning dry mouth	Y / N
Nighttime sweating	Y / N
Osteoporosis	Y / N
Prior orthodontic treatment	Y / N
Rheumatic fever	Y / N
Swollen, stiff or painful joints	Y / N
Tonsillectomy	Y / N
Injury to face, head, mouth, teeth	Y / N
Irregular heart beat	Y / N
Low blood pressure	Y / N
Migraines	Y / N
Muscle spasms or cramps	Y / N
Osteoarthritis	Y / N
Poor circulation	Y / N
Recent excessive weight gain	Y / N
Shortness of breath	Y / N
Thyroid problems	Y / N
Wisdom teeth extraction	Y / N

Patient Name: ______________________________

Have any members of your family (blood relatives) had:

Heart disease	Y / N
High blood pressure	Y / N
Diabetes	Y / N
A sleep disorder	Y / N

How often do you consume alcohol within 2-3 hours of bedtime?

Never   Once a week   Several days a week   Daily   Occasionally

How often do you take sedatives within 2-3 hours of bedtime?

Never   Once a week   Several days a week   Daily   Occasionally

How often do you consume caffeine within 2-3 hours of bedtime?

Never   Once a week   Several days a week   Daily   Occasionally