TOTAL HEALTH SLEEP SOLUTIONS, INC.

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New Patient Questionnaire

Name _____ DOB _____

Symptoms

Epworth Sleepiness Scale - Use the following scale to choose the most appropriate number for each situation.

0= No chance of dozing 1= Slight chance of dozing 2= Moderate chance of dozing 3= High chance of dozing

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g. a theater or 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 and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
	TOTAL			

Thornton Snoring Scale – Use the following scale to choose the most appropriate number for each situation.

0= Never 1= Infrequently (1 night/week) 2= Frequently (2-3 nights/week) 3= Most of the time (4+ nights/week)

My snoring affects my relationship with my partner	0	1	2	3
My snoring causes my partner to be irritable or tired	0	1	2	3
My snoring requires us to sleep in separate rooms	0	1	2	3
My snoring is loud	0	1	2	3
My snoring affects people when I am sleeping away from home	0	1	2	3
	TOTAL			

Other Complaints – Please check any other complaints below

- ☐ Frequent snoring
- ☐ Excessive daytime sleepiness (EDS)
- ☐ Difficulty falling asleep
- ☐ Waking up gasping
- ☐ Nighttime heartburn or GERD
- ☐ Morning headaches
- ☐ Clenching or grinding teeth at night
- ☐ Neck or facial pain
- ☐ I have been told that I stop breathing when I sleep
- ☐ Irritability or mood swings
- ☐ Snoring which affects the sleep of others
- ☐ Others have observed that I stop breathing while I sleep
- ☐ Difficulty in maintaining sleep
- ☐ Choking while sleeping
- ☐ Feeling unrefreshed in the morning
- ☐ Nasal problems or difficulty breathing through the nose
- ☐ TMJ or jaw pain
- ☐ Sounds in jaw joint (clicking, popping, or grating)
- ☐ Memory problems
- ☐ Other

Subjective Signs/Symptoms

Rate your overall energy level on a scale of 0-10 (10 being the highest)		
Rate your sleep quality on a scale of 0-10 (10 being the highest)		
Have you been told you snore?	YES	NO
Rate the sound of your snoring on a scale of 0-10 (10 being the highest)		
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 morning headaches		
Do you have a bed time partner?	YES	NO
If yes, do they sleep in the same room?	YES	NO
How many times per night does your bedtime partner notice you quit breathing?		

Previous Treatments

Sleep Studies
Please list all previous sleep study dates and locations.

CPAP Intolerance
Have you tried a CPAP? YES NO

Dental Devices
Are you currently wearing a dental device specifically designed to treat sleep apnea? YES NO

Have you previously tried a dental device for sleep apnea treatment? YES NO

Surgery
Have you tried surgery for snoring or sleep apnea? YES NO

If yes, please list the name of the surgery, surgeon and date of surgery.

Other Attempted Therapies
Please comment about other therapy attempts and how each impacted your snoring and apnea and sleep quality.

Health History

Premedication
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?

Allergens
Do you have any known allergens (for example: aspirin, latex, penicillin, etc)? YES NO
If yes, please select from the list below:

☐ Acrylic	☐ Antibiotics	☐ Aspirin
☐ Barbiturates	☐ Codeine	☐ Iodine
☐ Latex	☐ Jewelry	☐ Local Anesthetics
☐ Metals	☐ Penicillin	☐ Plastic
☐ Sedatives	☐ Sleeping Pills	☐ Sulfa Drugs

Please add any comments or additional allergens below:

Medications
Are you currently taking any medications? YES NO

If yes, please list name, dosage, frequency and reason below:

Medical History

☐ AIDs or HIV	☐ Alzheimer's	☐ Anemia
☐ Angina/Chest Pain	☐ Arteriosclerosis	☐ Arthritis/Gout
☐ Artificial Joints	☐ Asthma	☐ Autoimmune Disorders

☐	Bleeding Easily	☐	Breathing Problems	☐	Bulimia/Anorexia
☐	Cancer/Tumors	☐	Chemotherapy	☐	Chronic Fatigue
☐	Chronic Sinus Problems	☐	Congestive Heart Failure (CHF)	☐	Chronic Obstructive Pulmonary (COPD)
☐	Current Pregnancy/Nursing	☐	Diabetes	☐	Difficulty Concentrating
☐	Dizziness	☐	Emphysema	☐	Epilepsy
☐	Fibromyalgia	☐	Frequent Sore Throats	☐	Gastroesophageal Reflux (GERD)
☐	Hayfever	☐	Heart Attack	☐	Heart Disorder
☐	Herat Surgery	☐	Heart Valve Replacement	☐	Heartburn
☐	Hemophilia	☐	Hepatitis	☐	High Blood Pressure
☐	Hypoglycemia (Low Blood Sugar)	☐	Immune System Disorder	☐	Irregular Heart Beat
☐	Jaundice	☐	Kidney Problems	☐	Leukemia
☐	Liver Disease	☐	Low Blood Pressure	☐	Mitral Valve Prolapse
☐	Muscle Spasms or Cramps	☐	Nervousness	☐	Nighttime Sweating
☐	Osteoarthritis	☐	Osteoporosis	☐	Parkinson's
☐	Poor Circulation	☐	Psychiatric Care	☐	Radiation
☐	Recent Excessive Weight Gain	☐	Rheumatic Fever	☐	Rheumatism
☐	Scarlet Fever	☐	Shortness of Breath	☐	Stomach Disorders
☐	Stroke	☐	Swollen, Stiff or Painful Joints	☐	Thyroid Problems
☐	Tonsillectomy	☐	Tuberculosis	☐	Ulcers

Dental History

How would you describe your dental health?	Excellent	Good	Fair	Poor
Have you ever had teeth extracted?			YES	NO
Do you wear removable partials?			YES	NO
Do you wear dentures?			YES	NO
Have you worn orthodontics (braces)?			YES	NO
Does your TMJ (jaw joint) click or pop?			YES	NO
Do you have pain in this joint?			YES	NO
Have you 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 morning dry mouth?			YES	NO
Have you ever had injury to your head, face, neck, mouth or teeth?			YES	NO
Are you planning to have dental work done in the near future?			YES	NO
Do you clinch or grind your teeth?			YES	NO

Family History

Have genetic members of your family had Heart Disease?	YES	NO
Have genetic members of your family had High Blood Pressure?	YES	NO
Have genetic members of your family had Diabetes	YES	NO
Have genetic members of your family been diagnosed or treated for a sleep disorder?	YES	NO

Social History

Alcohol Consumption	How often do you consume alcohol within 2-3 hours of bedtime?	
DAILY	OCCASIONALLY	RARELY/NEVER
Sedative Consumption	How often do you take sedative within 2-3 hours of bedtime?	
DAILY	OCCASIONALLY	RARELY/NEVER
Caffeine Consumption	How often do you consume caffeine within 2-3 hours of bedtime?	
DAILY	OCCASIONALLY	RARELY/NEVER

Do you smoke?	YES	NO
If yes, number of packs per day:		
Do you use chewing Tobacco?	YES	NO

By signing below, I agree that I have completed this form to the best of my knowledge and ability.

Signature _____ **Date** _____