HollowBrook Sleep

PATIENT QUESTIONNAIRE

_____ _____ / _____ / _____ _____

PATIENT NAME DATE OF BIRTH TODAY'S DATE

WHAT ARE YOUR CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

PLEASE NUMBER YOUR COMPLAINTS WITH 1 BEING THE MOST SEVERE, 2 BEING THE NEXT MOST SEVERE AND SO ON.

TMD/PAIN COMPLAINTS

_____ BACK PAIN
_____ DIFFICULTY SWALLOWING
_____ DIZZINESS
_____ EAR CONJESTION
_____ EAR PAIN
_____ EYE PAIN
_____ FACIAL PAIN
_____ HEADACHES
_____ JAW CLICKING/POPPING
_____ JAW JOINT NOISES
_____ JAW LOCKING
_____ JAW PAIN
_____ LIMITED MOUTH OPENING
_____ MIGRAINES
_____ MORNING HEAD PAIN
_____ MUSCLE TWITCHING
_____ NECK PAIN
_____ NOCTURNAL TEETH GRINIDING
_____ PAIN WHEN CHEWING
_____ RINGING IN THE EARS
_____ THROAT PAIN
_____ SHOULDER PAIN
_____ SINUS CONGESTION
_____ VISUAL DISTURBANCES

SLEEP/BREATHING COMPLAINTS

_____ CPAP INTOLERANCE
_____ DIFFICULTY FALLING ASLEEP
_____ FATIGUE
_____ UNREFRESEJED UPON WAKING
_____ WITNESSES APNEIC EVENTS
_____ FREQUENT HEAVY SNORING
_____ SNORING AFFECTS OTHERS
_____ GASPING WHEN WAKING UP
_____ SLEEPY WHILE DRIVING
OTHER: _____
_____ MORNING HORSENESS
_____ NIGHTIME CHOKING SPELLS
_____ DAYTIME DROWSINESS
_____ SWELLING IN ANKLES/FEET

SYMPTOMS

HEADPAIN

❑ ENTIRE HEAD (GENERALIZED)

❑ TOP OF HEAD

❑ FRONT OF HEAD ❑ RIGHT ❑ LEFT ❑ BOTH

❑ BACK OF HEAD ❑ RIGHT ❑ LEFT ❑ BOTH

❑ IN YOUR TEMPLES ❑ RIGHT ❑ LEFT ❑ BOTH

JAW PAIN

❑ ON OPENING ❑ RIGHT ❑ LEFT ❑ BOTH

❑ WHILE CHEWING ❑ RIGHT ❑ LEFT ❑ BOTH

❑ AT REST ❑ RIGHT ❑ LEFT ❑ BOTH

JAW SYMPTOMS

❑ JAW POPPING ❑ JAW LOCKS CLOSED

❑ JAW LOCKS OPEN ❑ TEETH GRINDING

❑ JAW CLICKING ❑ RIGHT ❑ LEFT ❑ BOTH

MOUTH AND NOSE RELATED CONDITION

❑ BURNING TONGUE ❑ BROKEN TEETH

❑ FREQUENT BITING OF CHEEK ❑ TEETH CLENCHING

❑ FREQUENT SNORING ❑ DRY MOUTH

EAR RELATED CONDITIONS

❑ BUZZING IN THE EARS

❑ TINNITUS (RINGING IN EARS)

❑ EAR PAIN

❑ EAR CONGESTION

❑ PAIN IN FRONT OF THE EAR

❑ HEARING LOSS

❑ RECURRENT EAR INFECTIONS

❑ PAIN BEHIND THE EAR

EYE RELATED CONDITIONS

❑ BLURRED VISION

❑ EYE PAIN

❑ PAIN OR PRESSURE BEHIND THE EYE

THROAT / NECK / BACK RELATED CONDITIONS

❑ LOWER BACK PAIN

❑ MIDDLE BACK PAIN

❑ UPPER BACK PAIN

❑ CHRONIC SORE THROAT

❑ CONSTANT FEELING OF FOREIGN OBJECT IN THROAT

❑ DIFFICULTY SWALLOWING

❑ LIMITED MOVEMENT OF NECK

❑ NECK PAIN

❑ NUMBNESS IN HANDS OR FINGERS

❑ SCIATICA

❑ SCOLIOSIS

❑ SHOULDER PAIN

❑ SHOULDER STIFFNESS

❑ SWELLING IN THE NECK

❑ SWOLLEN GLANDS

❑ THYROID ENLARGEMENT

❑ TIGHTNESS IN THROAT

❑ TINGLING IN HANDS OR FINGERS

❑ CHRONIC SINUSITIS

HEAD PAIN HISTORY

WHICH SIDE OF THE HEAD ACHES WORSE? ❑ RIGHT ❑ LEFT ❑ BOTH ❑ _____

HEACHACHE SPREADS TO: ❑ TEMPLE ❑ BACK OF HEAD ❑ FOREHEAD ❑ _____

HEADACHES ON A PAIN SCALE OF 0-10? _____

NECK PAIN ON A PAIN SCALE OF 0-10? _____

FACIAL PAIN ON A PAIN SCALE OF 0-10? _____

FREQUENCY OF HEADACHES? ❑ 0-3/MO. ❑ 3-6/MO ❑ CONSTANT ❑ _____

DURATION OF HEADADCHES? ❑ SECONDS. ❑ MINUTES ❑ HOURS ❑ DAYS ❑ WEEKS

JAW PAIN ON SCALE OF 0-10? _____

WHEN HAVING PAIN DO YOU EXPERIENCE ANY OF THE FOLLOWING?

❑ DIZZINESS ❑ NAUSEA ❑ THROBBING

❑ DOUBLE VISION ❑ SENSITIVITY TO LIGHT ❑ VOMITING

❑ FATIGUE ❑ SENSITIVITY TO NOISE ❑ BURNING

OTHER _____

HISTORY OF SYMPTOMS

IS THERE ANYTHING THAT MAKES YOUF PAIN OF DISCOMFORT WORSE? _____

_____

IS THERE ANYTHING THAT MAKES YOUR PAIN OR DISCOMFORT BETTER? _____

_____

WHAT OTHER INFORMATION IS IMPORTANT REGARDING THE PAIN OR CONDITION? _____

_____

HISTORY OF TREATMENT

PRACTITIONER'S NAME _____ SPECIALTY _____

TREATMENT_____ DATE LAST SEEN _____

PRACTITIONER'S NAME _____ SPECIALTY _____

TREATMENT_____ DATE LAST SEEN _____

PRACTITIONER'S NAME _____ SPECIALTY _____

TREATMENT_____ DATE LAST SEEN _____

PRACTITIONER'S NAME _____ SPECIALTY _____

TREATMENT_____ DATE LAST SEEN _____

PRACTITIONER'S NAME _____ SPECIALTY _____

TREATMENT_____ DATE LAST SEEN _____

EPWORTH SLEEP QUESTIONNAIRE

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS?

	NO CHANCE	SLIGHT	MODERATE	HIGH
SITTING AND READING	❑	❑	❑	❑
WATCHING TV	❑	❑	❑	❑
SITTING INACTIVE IN PUBLIC PLACE	❑	❑	❑	❑
AS A PASSENGER IN A CAR FOR AN HOUR W/O BREAK	❑	❑	❑	❑
LYING DOWN IN THE AFTERNOON TO REST	❑	❑	❑	❑
SITTING AND TALKING TO SOMEONE	❑	❑	❑	❑
SITTING QUIETLY AFTER LUNCH, WITHOUT ALCOHOL	❑	❑	❑	❑
IN A CAR, WHILE STOPPED IN TRAFFIC FOR A FEW MINUTES	❑	❑	❑	❑

SLEEP HISTORY

SLEEP ONSET LATENCY _____ MINUTES NORMAL BED TIME _____

HOURS OF SLEEP AT NIGHT _____ NUMBER OF TIMES YOU GET UP AT NIGHT _____

NUMBER OF TIMES WAKING TO URINATE _____

DO YOU TAKE A SLEEP AID? ❑ YES ❑ NO IF YES, NAME OF MEDICATION _____

DO YOU HAVE ANY OF THE FOLLOWING WHILE YOU SLEEP:

❑ GRINDING TEETH ❑ DRY MOUTH ❑ EXCESSIVE MOVEMENT

❑ GASPING ❑ RESTLESS LEGS ❑ DREAMING

❑ WAKING UP AND HAVING DIFFICULTY RETURNING TO SLEEP

DO YOU EXPERIENCE SLEEPINESS WHILE DRIVING? ❑ YES ❑ NO

DO YOU WAKE UP UNREFRESHED? ❑ YES ❑ NO

DO YOU WAKE WITH HEADACHES? ❑ YES ❑ NO

HOW FREQUENTLY DO YOU TAKE NAPS? ❑ DAILY ❑ NEVER ❑ OCCASIONAL ❑ OTHER_____

SNORING FREQUENCY: ❑ SELDOM ❑ DAILY ❑ OFTEN ❑ NEVER ❑ OTHER_____

SNORING SEVERITY: ❑ LIGHT ❑ MODERATE ❑ LOUD ❑ OTHER_____

SLEEP STUDIES

HAVE YOU BEEN PREVIOUSLY DIAGNOSED WITH OBSTRUCTIVE SLEEP APNEA? ❑ YES ❑ NO

IF YES, HOW LONG AGO WERE YOU DIAGNOSED? _____

IS YOUR SLEEP APNEA WORSE WHEN

❑ SLEEPING ON BACK ❑ DRIKING ALCOHOL LATE AT NIGHT

HAVE YOU HAD A SLEEP STUDY? ❑ HOME SLEEP STUDY ❑ POLYSOMNOGRAPHIC EVALUATION AT A SLEEP CENTER

SLEEP CENTER NAME _____ SLEEP STUDY DATE _____

FOR OFFICE USE ONLY

CONFIRMED DIAGNOSIS OF: _____ DATE OF DIAGNOSIS: _____

		REM	SUPINE	SIDE
AN RDI OF	_____	_____	_____	_____
AN AHI OF	_____	_____	_____	_____
NADIR Sp02	_____	T90_____	ODI_____	

SLOW WAVE SLEEP ❑ DECREASED ❑ NONE

REM SLEEP ❑ DECREASED ❑ NONE

CPAP DEVICE

DO YOU CURRENLTY USE A CPAP? ❑ YES ❑ NO

IF YES, WHAT ARE YOUR CURRENT CPAP SETTINGS? _____

IF YOU HAVE ATTEMPTED TREATMENT WITH A CPAP DEVICE, BUT COULD NOT TOLERATE IT, PLEASE COMPLETE BELOW:

❑ REFUSES CPAP

❑ CLAUSTROPHIC

❑ CPAP RESTRICTED MOVEMENTS IN SLEEP

❑ NOT EFFECTIVE

❑ MASK DID NOT FIT PROPERLY

❑ NOISY

❑ LATEX ALLERGY

❑ CUMBERSOME

❑ NOISE DISTURBS SLEEP/PARTNERS SLEEP

❑ MASK LEAKS

❑ DISCOMFORT FROM HEAD GEAR

❑ UNCONTIOUS NEED TO REMOVE CPAP

❑ DID NOT RESOLVE SYMPTOMS

❑ PRESSURE ON UPPER LIP CAUSING TOOTH PROBLEMS

❑ DISTRUPTED / INTERRUPTED SLEEP

❑ OTHER _____

OTHER THERAPY ATTEMPTS

PLEASE SELECT ANY OTHER THERAPIES TRIED:

❑ DIETING
❑ PILLAR PROCEDURE
❑ POSITIONAL THERAPY
❑ WEIGHTLOSS
❑ SMOKING CESSATION
❑ NASAL STRIPS
❑ UVULOPLASTY
❑ CPAP
❑ UVULECTOMY
❑ BIPAP

HISTORY OF ACCIDENT

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT RELATED TO THE CURRENT VISIT.

DATE OF ACCIDENT OR INCIDENT _____

CAUSE OF THE PAIN OR CONDITION (SELECT ONE)

❑ MOTOR VEHICLE ACCIDENT
❑ ATHLETIC ENDEAVOR
❑ HIT AN OBJECT
❑ MOTORCYCLE ACCIDENT
❑ FIGHT
❑ ILLNESS
❑ WORK RELATED ACCIDENT
❑ FALL
❑ ORTHODONTICS
❑ PLAYGROUND ACCIDENT
❑ HIT BY AN OBJECT
❑ DENTAL PROCEDURE
❑ WHIPLASH
❑ OTHER_____

PLEASE PROVIDE MORE DETAIL ABOUT THE ACCIDENT / INCIDENT.
(PASSENGER / DRIVER / PEDESTRIAN; LOCATION OF YOUR ACCIDENT; WHAT DID YOU HIT / WHAT HIT YOU)

_____

_____

_____

_____

IF IN A VEHICLE, WHERE WAS THE VEHICLE HIT?

❑ FRONT END ❑ REAR END ❑ FRONT PASSENGER SIDE

❑ FRONT DRIVER'S SIDE ❑ REAR PASSENGER SIDE ❑ REAR DRIVER'S SIDE

❑ HEAD ON ❑ DRIVER'S SIDE ❑ PASSENGER SIDE

OTHER_____

INDICATE IF THERE WAS ANY TRAUMA

❑ FOREHEAD ❑ TOP OF HEAD ❑ FACE

❑ CHIN ❑ SIDE OF HEAD ❑ TEETH

❑ JAW ❑ BACK OF HEAD ❑ OTHER

_____

DID YOU FORCIBLY HIT YOURSELF ON:

❑ STEERING WHEEL ❑ DRIVER'S SIDE WINDOW ❑ HEADREST

❑ WINDSHIELD ❑ PASSENGER SIDE DOOR ❑ SEAT

❑ PASSENGER SIDE WINDOW ❑ DRIVER'S SIDE DOOR ❑ ROOF

❑ INTERIOR OF CAR ❑ OTHER_____

I CERTIFY THAT THE MEDICAL HISTORY IS COMPLETE AND ACCURATE.

_____ _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE

Because of HIPPA Federal Regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required, including a full report of examination findings, diagnosis and treatment program(s) to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits payable for related services.

_____ _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN

MODERATE PAIN

SEVERE PAIN

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating