



1. PATIENT INFORMATION

Full name: _____ Date of birth: _____ Gender: _____

Address: _____ Best contact #: _____

City: _____ State: _____ Zip: _____ Alternative contact #: _____

Email: _____ Weight (lbs): _____ Height (in): _____

2. SLEEP APNEA RISK ASSESSMENT

- a. Check "Yes" or "No" in response to each question.
- b. If filling on paper, add up the points for each "Yes" answer and write in the "TOTAL" box. If completing in PDF form this section will fill automatically.
- c. Select the corresponding Risk Level

Have you ever been told you stop breathing while asleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No	8
Have you ever fallen asleep or nodded off while driving?	<input type="checkbox"/> Yes <input type="checkbox"/> No	6
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	6
Do you feel excessively sleepy during the day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	4
Do you snore or have you ever been told that you snore?	<input type="checkbox"/> Yes <input type="checkbox"/> No	4
Have you had weight gain and found it difficult to lose?	<input type="checkbox"/> Yes <input type="checkbox"/> No	2
Have you taken medication for, or been diagnosed with high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	2
Do you kick or jerk your legs while sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	<input type="checkbox"/> Yes <input type="checkbox"/> No	3
Do you wake up with headaches during the night or in the morning?	<input type="checkbox"/> Yes <input type="checkbox"/> No	3
Do you have trouble falling asleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No	4
Do you have trouble staying asleep once you fall asleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No	4

Check the risk level below that pertains to the score box on the right.

TOTAL:

RISK LEVEL:

LOW (0-7)

MODERATE (8-11)

HIGH (12-15)

SEVERE (16+)

3. SIGNS & SYMPTOMS

- Hypertension
- Depression
- Stroke/heart disease
- Teeth grinding
- Family history of snoring or sleep apnea
- Neck circumference (in): _____
- Snoring
- Diabetes
- Acid reflux
- Unrefreshed sleep

4. SLEEP HISTORY

- Have you ever been diagnosed with a sleep disorder? Yes No
- Have you ever used a CPAP machine? Yes No
- Are you currently using a CPAP machine? Yes No
- If yes, do you use your CPAP less than 5 times per week? Yes No
- Have you tried CPAP, and would you prefer an oral appliance? Yes No

PHYSICIAN: please sign to confirm you have reviewed this form with the patient.

PATIENT: please present completed questionnaire, ID and medical insurance card to front desk.

Signature

Date