Name _____

Birthdate / /

Visit Date / /

Sleep Medicine *New Patient Form*

Ht WT BP HR Neck Circumference

FOR THIS APPOINTMENT

Why are you coming to see the doctor today? _____

How long have you had this problem? _____

Have you seen another doctor for this problem? ☐ No ☐ Yes

SLEEP HISTORY

Do you have or has anyone noticed that you have the following symptoms? (check all that apply)

- ☐ Snore
- ☐ Have restless sleep
- ☐ Talk in sleep
- ☐ Walk in sleep
- ☐ Have creeping or crawling in legs
- ☐ Stop breathing while sleeping
- ☐ Have morning headaches
- ☐ Take medicine for sleep
- ☐ Have leg jerks
- ☐ Feel like you have to move your legs
- ☐ Wake up gasping for air
- ☐ Acting out your dreams
- ☐ Have vivid dreams
- ☐ Have night time wheezing
- ☐ Can't lie down flat

Have you ever had a Sleep Study before? ☐ No ☐ Yes If yes, when? _____

Have you ever felt weak in your muscles when laughing, surprised, angry, or any other emotion? ☐ No ☐ Yes

Have you ever seen or heard things that aren't there while falling asleep or while waking up from sleep? ☐ No ☐ Yes

Have you ever felt like you cannot move while falling asleep or while waking up from sleep? ☐ No ☐ Yes

What is your typical Sleep Schedule:

on work days? Bedtime_____ Rise time _____ How long to fall asleep?_____

on off days? Bedtime_____ Rise time _____ How long to fall asleep?_____

Are you: sleepy during the day? ☐ No ☐ Yes fatigued during the day? ☐ No ☐ Yes

How many times do you wake up during the night? _____ For restroom visits? ☐ No ☐ Yes

How long does it take to fall back asleep? _____ minutes / _____ hours

If you have difficulty falling asleep, what do you do? _____

Is your nighttime sleep refreshing? ☐ No ☐ Yes

Do you take naps? ☐ No ☐ Yes If yes _____

How many days per week do you nap?_____ How long are your naps? _____ minutes / _____ hours

Are they refreshing? ☐ No ☐ Yes Do you dream during the naps? ☐ No ☐ Yes

EPWORTH SLEEPINESS SCALE

Estimate your risk of falling asleep in the following situations, using the scale below.

SITUATION	CHANCE OF DOZING
Sitting and Reading	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
Watching TV	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
Sitting inactive in a public place (e.g. theatre or meeting)	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
As a passenger in a car for an hour without a break	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
Lying down to rest in the afternoon when circumstances permit	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
Sitting and talking to someone	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
Sitting quietly after a lunch without alcohol	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
In a car, while stopped for a few minutes in traffic	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high

CHECK BOX IF YOU HAVE OR HAD ANY OF THE FOLLOWING

- ☐ Stroke or TIA
- ☐ Seizures
- ☐ Kidney disease
- ☐ Nasal or sinus problems
- ☐ High blood pressure
- ☐ Drug or alcohol addiction
- ☐ Lung disease
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease
- ☐ Thyroid problems
- ☐ Neurological disease

Name _____

Birthdate ___/___/___

Visit Date ___/___/___

PAST OR CURRENT MEDICAL PROBLEMS

_____

_____

_____

PAST SURGERIES

_____

_____

_____

ALLERGIES

Medicine	Reaction	Medicine	Reaction

MEDICATIONS

Medication	Dose	Medication	Dose

FAMILY HISTORY

Is there anyone in your family with any of the following conditions:

☐ Seizures ☐ Dementia ☐ Insomnia ☐ Sleep Apnea ☐ Parkinson's Disease ☐ Excessive Sleepiness ☐ High blood pressure ☐ Coronary Artery Disease ☐ Diabetes ☐ Narcolepsy

Is there someone in your family with an illness similar to the one for which you are seeing the doctor today?

_____

PERSONAL HISTORY

Education Level and Degree(s) _____ Occupation _____

Marital Status _____ With whom do you live? _____

Do you currently smoke? ☐ No ☐ Yes Did you used to smoke? ☐ No ☐ Yes If yes, when did you quit? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks per week? _____

Do you currently use recreational drugs? ☐ No ☐ Yes

Do you have a history of using recreational drugs? ☐ No ☐ Yes

Do you drink coffee, caffeinated sodas, energy drinks or teas? ☐ No ☐ Yes If yes, how many cups per day? ____

Do you exercise regularly? ☐ No ☐ Yes How many days per week? _____

REVIEW OF SYSTEMS Only indicate problems occurring in the last 2 weeks.

General:
- ☐ Fevers or sweats
- ☐ Weight gain or loss _____ lbs

Neurologic:
- ☐ Passing out
- ☐ Numbness or tingling
- ☐ Headache

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Stressful life event

Ear, Nose, Throat:
- ☐ Sinus congestion

Respiratory:
- ☐ Trouble breathing
- ☐ Coughing or wheezing

Musculoskeletal:
- ☐ Back pain
- ☐ Muscle aches or cramps
- ☐ Joint pain

Genitourinary:
- ☐ Frequent urination

Cardiovascular:
- ☐ Chest discomfort
- ☐ Rapid or skipped heartbeats

Endocrine:
- ☐ Heat or cold intolerance
- ☐ Menopausal symptoms
- ☐ Thyroid problems

Gastrointestinal:
- ☐ Nausea or vomiting
- ☐ Heartburn

If you are NOT currently having any of the problems listed above, check here ☐

Current Providers

Primary Care

Sleep Physician

General Dentist

Other

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Stillwater Dental to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance to pay directly to Stillwater Dental or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature **Date**