SNORING & SLEEP APNEA
ORAL APPLIANCE CENTRE
TASMANIA

Patient History

Patient Information:

Name: Title: _____ Given Name: _____ Family Name: _____

Preferred Name: _____

Address: _____

Contact: _____

Email: _____

Date of birth: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____

Marital/Partner Status: _____

Children: _____

Do you have Private Health cover with Extras? Yes / No Name of fund: _____

How did you find out about our clinic?

Were you referred or recommended by: GP / ENT / Dentist / Sleep Specialist?

Referrer name: _____

Radio / Web / Road Signage / Mail / TV / Newspaper / Friend / Other _____

Chief Concerns: (Please circle any applicable concerns)

Snoring / Sleep Apnoea / Interrupted Sleep / Tiredness / Difficulty Concentrating / Drowsy When Driving

Other: _____

What effect are these concerns having on your life? _____

Have you seen any health professionals for this problem? Yes / No Who? _____

Have you had a diagnosis of Sleep Apnoea? Yes / No

If yes, where did you have your sleep study? Location: _____ Year: _____

Have you had any previous treatment for Sleep Apnoea? Yes /No

Describe: _____

How many caffeinated beverages do you consume each day (cola / tea / coffee)? _____

How many alcoholic beverages do you consume each day? _____

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Have you ever been a smoker? Yes / No How many each day? _____ When did you quit? _____

Your GP: _____ Suburb: _____

Your Dentist: _____ Suburb: _____

Symptoms: (Please circle yes or no, do not leave blank)

Do you feel well and refreshed in the morning?	Yes /N o
Has anyone heard you stop breathing or do you gasp or choke during sleep?	Yes / No
Are you sleepy during the day?	Yes / No
Do you experience sleepiness driving?	Yes / No
Do you have memory or concentration problems?	Yes / No
Do you suffer from headaches?	Yes / No
Do you experience dry mouth?	Yes / No
Do you have restless legs in sleep:	Yes / No

Sleeping Pattern: (please answer all questions)

How long do you take to fall asleep? _____ How often do you awaken in the night? _____

The main reason for waking up? _____ Average total hours sleep per night? _____

What time do you wake in the morning? _____ What time do you go to bed at night? _____

Medical History: Have you ever had any of the following? (Please circle yes or no, do not leave blank)

High blood pressure	Yes / No	Heart ailment	Yes / No
Asthma / chest / breathing problems	Yes / No	Diabetes	Yes /No
Hay fever	Yes/ No	Reflux	Yes / No
Excessive bleeding / blood disorder	Yes / No	Epilepsy	Yes / No
Under treatment for serious illness	Yes / No	Pregnant	Yes / No

List any other previous illnesses or operations: _____

Current medications: _____

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Allergies: _____

Exercise endurance: (Please circle) Normal / Restricted

Any family history of serious health or sleep disorders: _____

Dental History

When did you last have a dental check-up: _____

Have you ever had orthodontic treatment / braces? Yes / No

Are you aware of clenching or grinding your teeth? Day / Night Yes / No

Do you have any problems with chewing or jaw movements? Yes / No

Patient signature: _____ Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to sitting and reading just feeling tired? This refers to your recent/current way of life. Even if you have not done some of these things recently, try to determine how they would affect you.

Epworth Sleepiness Scale Situation

Situation	Would never dose	Slight chance of dosing	Moderate chance of dozing	High chance of dozing
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
3 Sitting, inactive in a public place [e.g., cinema, meeting]	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
3 Lying down to rest in the afternoon when able	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
Driving a car, while stopped for a few minutes in traffic	0	1	2	3
Total = out of 24 _____				

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OSA 50

Obesity: Waist circumference (Men>102cm F>88cm)	+3	
Snoring: Has your snoring ever bothered other people?	+3	
Apnoea's: Has anyone noticed that you stop breathing during your sleep?	+2	
50: Are you aged 50 years or over?	+2	
TOTAL (5 points or more indicates moderate to high risk)		TOTAL ___/10

STOPBANG

Do you snore loudly?	+1	
Louder than talking or loud enough to be heard through closed doors	+1	
Do you often feel tired, fatigued, or sleepy during the daytime?	+1	
Are you aged 50 years or over?	+1	
Do you have (or are you being treated for) high blood pressure?	+1	
Has anyone observed you stop breathing during sleep?	+1	
Age >50 years	+1	
BMI >35 kg/m²	+1	
Neck Circumference >40 cm	+1	
Male	+1	
TOTAL (4 points or more indicates moderate to high risk)	+1	__/9