Snoring and Obstructive Sleep Apnoea Medical History Questionnaire

It is important that you take the time to complete **ALL** the following information prior to your appointment.
Please **DO NOT** leave any section blank or unanswered.

PLEASE BRING THE COMPLETED DOCUMENT TO YOUR APPOINTMENT

Date: _____/_____/_____	Private Health Insurance: Number: Medicare Number:		Male ☐ Female ☐
Given Names Dr / Mr / Mrs / Ms / Miss			Date of Birth: _____/_____/_____ dd mm yy
Surname		Occupation:	
Contact Details	Home Phone: ( )	Business Phone: ( )	
	Mobile Phone:	Email:	
	Address:		Postcode:

Please provide the following information in **FULL**:

GP's First/Surname:	Practice Name:	Practice Address (incl Post Code):	Phone number:
Dentist's First/Surname:	Practice Name:	Practice Address (incl Post Code):	Phone number:

HEALTH HISTORY

Indicate below, the frequency of your snoring or apnoeic episodes?	Indicate below what you believe is the severity of your snoring or sleep apnoea:	Below, tick which symptoms & side-effects you suffer from:
Constant ☐ Irregular ☐	Mild ☐ Moderate ☐ Severe ☐	Sore Throat ☐ Daytime Drowsiness ☐ Depression ☐ Waking Tiredness ☐ Irritability ☐ Loss of Libido ☐ Weight Gain ☐ Poor Memory/Concentration ☐

What is your usual sleeping position? Lateral (on side)__ Supine (on back)__ Prone (on stomach)__

	Y	N	(Please circle)	Please tick if you have:
Do you have a gag reflex?	☐	☐	Mild Moderate Strong	Nasal Blockage ☐
Do you wear dentures or plates?	☐	☐	Upper Partial Full	*Permanent* ☐
			Lower Partial Full	*Occasional* ☐

Please list all health practitioners (including Complementary Medicine) you have seen for your snoring, sleep apnoea problems along with approximate dates and treatment performed including Sleep Studies: For example:

Practitioner	Address	Speciality	Treatment	approx dates
Dr Jones	15 Epworth Street, Ross	ENT	Soft Palate Surgery	Oct 2001

Have you had a sleep study conducted in the last 5 years: Yes / No Dates:_____

If YES please bring ALL copies of the sleep study reports with you to your initial consultation. If you do not have a copy, please arrange one to be sent to you or our rooms PRIOR to your consultation.

Have you had in the past 10 years or do you currently have any of the following conditions?

Please tick either 'Yes' or 'No'	Yes	No	Please tick either 'Yes' or 'No'	Yes	No
Anaphylaxis……..			Heart Palpations / Arrhythmias…		
Angina……			Heart Surgery……..		
Anxiety / Depression……			Heart Valve Replacement……		
Asthma……			Hepatitis A / B / C……..		
Bleeding Disorder……			HIV / AIDS……..		
Blood Pressure High / Low……			Insomnia……		
Blood Thinning Treatment……			Irritable Bowel Syndrome……..		
Bruise Easily……..			Kidney Disease……..		
Cancer……			Liver Jaundice		
Chemotherapy……			Lung Disease……		
Chronic Fatigue……			Nose Surgery……		
Cirrhosis of the Liver……			Osteoarthritis……		
Congestive Heart Failure……..			Osteoporosis……..		
Deep Vein Thrombosis……			Radiation Therapy……..		
Diabetes IDDM / NIDDM…….			Reflux……		
Drug Dependency……..			Rheumatic Fever……		
Elevated Cholesterol……..			Rheumatoid Arthritis……		
Emphysema……..			Sinus Surgery……..		
Endocarditis……..			Smoker 0-10 / 10-20 / >20 per day		
Epilepsy……..			Snoring / Sleep Apnoea		
Gastric / Peptic Ulcer……..			Stroke / Mini Stroke……..		
Hashimoto's Disease……..			Thrombocytopenia……		
Haemophilia……			Thyroid Problems……..		
Heart Attack……..			Tonsils Removed……		
Heart Murmur……			Von Willebrand's Disease……..		
Heart Pacemaker……			Wisdom Teeth Extractions……..		

Please list any other medical conditions not listed above:		
Have you had lap band surgery?	**Yes**	**No**
Have you used in the past any drugs recreationally? If yes, please list types and quantities (or years used)	**Yes**	**No**
Do you consume alcohol? If yes, please list quantity per day or week	**Yes**	**No**

Medications List: Please provide a detailed list of ALL prescription and non-prescription medications you are currently taking and the doses e.g. Aspirin 100mg 1 tablet once a day, Endep 25mg 1 tablet once a day, etc including herbal medicines such as St John's Wort, Ginko Biloba, etc.

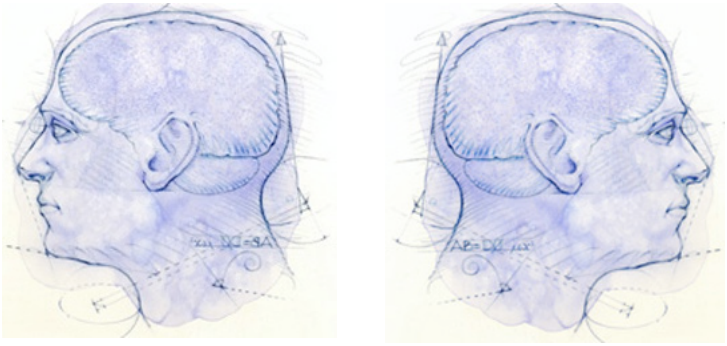
Medication	Quantity	Dosage

ALLERGIES: Please list any allergies or intolerances that you may have (food AND medications):

_____

Headaches and Jaw / Face Pain: Using the diagram below, indicate the location and type of any pain you have in the past or currently suffer from.

Left Side



Right Side

Onset:	*(please circle)*	morning	afternoon	evening	whilst asleep
Duration of headaches:	*(please circle)*	seconds	minutes	hours	days
Frequency of headaches:	*(please circle)*	occasional	daily	weekly	constant
Severity of headaches:	*(please circle)*	mild	moderate	severe	
Description:	*(please circle more than 1 if required)*	tension	crushing	migraine	cluster
		dull	band-like	burning	stabbing

Please list anything you attempt or do that relieves the pain:

_____

_____

Do you suffer from jaw pain? *(Please circle appropriate response)*

On opening or yawning?	Yes	No
On closing?	Yes	No
When chewing?	Yes	No

Do you: *(Please circle appropriate response)*

Clench your teeth?	Yes	No	Sometimes
Grind your teeth?	Yes	No	Sometimes

Do you suffer from any of the following jaw symptoms? *(Please circle appropriate response)*

Clicking jaw?	Yes	No	Sometimes
Jaw locking open?	Yes	No	Sometimes
Jaw locking shut?	Yes	No	Sometimes
Grating or grinding jaw noises?	Yes	No	Sometimes

In this section, descirbe your liklihood of falling asleep in the corresponding situations.

Epworth Scale	Likelihood of falling asleep 0 = Never; 1 = Sometimes; 2 = Likely; 3 = Highly Likely			
	0	1	2	3
Sitting Reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting Inactive in Public Place	☐	☐	☐	☐
Passenger in Car (1 hour)	☐	☐	☐	☐
Lying Down Rest Afternoon	☐	☐	☐	☐
Sitting Talking	☐	☐	☐	☐
Sitting After Lunch (No Alcohol)	☐	☐	☐	☐
Car While Stopped (3 minutes)	☐	☐	☐	☐
	Total Score		**/ 24**	

Patient Declaration **MHQ – Medical History Questionairre** **OSA – Obstructive Sleep Apnea** **OAT – Oral Appliane Therapy**	**Clinical Assessment**
• I understand that Dr Tony Eldridge is a dentist with a restricted practice in treating orofacial pain, TMJ disorders, oral medicine, oral surgery, and dental sleep medicine. Dr Eldridge has taken many post graduate courses and qualifications, and is a member of professional organisations that treat these conditions. • I understand that Dr Tony Eldridge has no affiliation with any company, laboratory, or single appliance, and does not condone or recommend over the counter appliances. • I have been examined and assessed and the diagnostic result and recommended treatment, at right, have been explained to me. • I have been advised that my snoring may be a symptom of OSA. • I have been advised that OAT can be suitable for the treatment of snoring and mild or moderate OSA, but may not be 100% effective in treating severe cases of OSA. • I have been advised that often, adjunctive treatment such as weight loss, diet, exercise, surgery, CPAP, or other treatments for snoring and OSA may be required. • I have been advised that sleep studies before and after commencement of OAT are required to properly manage my snoring and OSA condition. • I understand that Mandibular Repositioning Devices and Constant Positive Airway Pressure systems are mechanical aids that will only work while the appliance is worn. • I am aware that good oral hygiene is extremely important as the use of an oral appliance can exacerbate the formation of plaque and consequent decay. • I have been advised that regular 6 monthly dental checkups with my dentist are recommended to prolong the life of the appliance and to help minimise any dental complications. • I have been advised of the possible side effects of OAT and I undertake to contact the clinic promptly if I experience any unexpected side effects. • I understand that if I or any other practitiioner without prior consent makes adjustments to my oral appliance, all warranties are void and complications can occur. • I understand that some change to my bite position is possible and that this is an unavoidable consequence which must be balanced against the benefits of oral appliance therapy. • I understand that failure by me not to attend recall visits when requested may lead to serious complications or side effects to my health and the oral appliance. • I agree to pay all costs in full and all debt recovery costs associated with unpaid accounts in my name. • I declare that the information provided by me on pages 1 - 4 of the MHQ is, to the best of my knowledge, correct and accurate. • I have read and understand this declaration and hereby elect to commence treatment.	Diagnostic Results and Recommended Treatment Plan **Class I** OAT suitable as first line treatment. CPAP or other treatments do not appear to be necessary. Doctor Initial____ Patient Initial____ **Class II** OAT suitable as first line treatment. Other treatments such as surgery may be required as an adjunct. Doctor Initial____ Patient Initial____ **Class III** OAT not indicated as first line treatment. Surgery, CPAP or other treatments should be instigated as 1st choice. OAT may be considered as an adjunct on review of other treatments. Doctor Initial____ Patient Initial____ **Class IV** OAT not indicated. CPAP or other treatments required in the first instance. OAT may be considered if patient is not suitable or fails other treatment options. OAT is not guaranteed to be effective in controlling severe OSA and at all times CPAP must be considered as 1st line treatment. Doctor Initial____ Patient Initial____ **Class V** Patient refuses all other treatment options such as CPAP or surgery. Patient has trialed CPAP and / or had surgery and / or other adjunctive treatment and wishes to proceed with OAT. OAT is not guaranteed to be effective in controlling severe OSA and at all times CPAP must be considered as 1st line treatment. Doctor Initial____ Patient Initial____

Name: _____ **Signature:** _____ **Date**_____/_____/_____

Dr Tony Eldridge **Signature** **Date**_____/_____/_____