Sound Asleep Solutions

# PRE-APPOINTMENT QUESTIONNAIRE

**Texas City Fax: 409-938-8080**
**League City Fax: 281-334-3264**
**Email: info@soundasleepsolutions.com**

## 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

| | | |
|---|---|---|
| Have you ever been told you stop breathing while asleep? | ☐ Yes ☐ No | 8 |
| Have you ever fallen asleep or nodded off while driving? | ☐ Yes ☐ No | 6 |
| Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing? | ☐ Yes ☐ No | 6 |
| Do you feel excessively sleepy during the day? | ☐ Yes ☐ No | 4 |
| Do you snore or have you ever been told that you snore? | ☐ Yes ☐ No | 4 |
| Have you had weight gain and found it difficult to lose? | ☐ Yes ☐ No | 2 |
| Have you taken medication for, or been diagnosed with high blood pressure? | ☐ Yes ☐ No | 2 |
| Do you kick or jerk your legs while sleeping? | ☐ Yes ☐ No | 3 |
| Do you feel burning, tingling or crawling sensations in your legs when you wake up? | ☐ Yes ☐ No | 3 |
| Do you wake up with headaches during the night or in the morning? | ☐ Yes ☐ No | 3 |
| Do you have trouble falling asleep? | ☐ Yes ☐ No | 4 |
| Do you have trouble staying asleep once you fall asleep? | ☐ Yes ☐ No | 4 |
| **Check the risk level below that pertains to the score box on the right.** | **TOTAL:** | 0 |

| **RISK LEVEL:** | ☐ **LOW (0-7)** | ☐ **MODERATE (8-11)** | ☐ **HIGH (12-15)** | ☐ **SEVERE (16+)** |
|---|---|---|---|---|

## 3. SIGNS & SYMPTOMS

☐ Hypertension ☐ Snoring
☐ Depression ☐ Diabetes
☐ Stroke/heart disease ☐ Acid reflux
☐ Teeth grinding ☐ Unrefreshed sleep

☐ Family history of snoring or sleep apnea
☐ Neck circumference (in): _____

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

## 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.

_____ _____
*Signature* *Date*