

Patient name _____ Date of initial clinic visit _____

PLEASE COMPLETE THIS PAGE ONLY IF YOU HAVE BEEN EVALUATED FOR SLEEP PROBLEMS IN ANOTHER SLEEP CENTER IN THE PAST.

Please explain briefly why you have asked us to take over for your sleep medicine care:

Have you been diagnosed with **obstructive sleep apnea**? YES NO What year? _____

Where (name of sleep center(s), as well as city and state)? _____

Do you recall actually meeting with and being evaluated face-to-face by a **physician specializing in sleep medicine**? YES NO

If so, provide the physician's **name**: _____

Do you feel you have a good **understanding** of sleep apnea and its treatments? YES NO

When was your **last** followup clinic visit in that sleep center? _____

Please list any **other** diagnosed **sleep disorders**: _____

Have you been treated with a **positive airway pressure** device (like **CPAP**)? YES NO

If so, **pressure** setting: _____ Your **equipment company** (and location): _____

If so, did you **feel better** after starting regular use of the device? YES NO

If so, are you **still using** the device? YES NO

If not, **why not**? _____ **Age** of your device: _____

Do you **weigh** (more) or (less) than when you were first diagnosed? By how much? _____ lb.

If you have been having **problems** with CPAP use, please check-mark the appropriate boxes:

<input type="checkbox"/>	Strong air pressure	<input type="checkbox"/>	Weak air pressure	<input type="checkbox"/>	Otherwise uncomfortable pressure
<input type="checkbox"/>	Mask discomfort	<input type="checkbox"/>	Mask leak	<input type="checkbox"/>	Red marks on face, head, or neck
<input type="checkbox"/>	Headgear slippage	<input type="checkbox"/>	Mask and filters are old	<input type="checkbox"/>	CPAP device requires replacement
<input type="checkbox"/>	Dry throat	<input type="checkbox"/>	Dry mouth	<input type="checkbox"/>	Dry throat and dry mouth
<input type="checkbox"/>	Water in tubing	<input type="checkbox"/>	Water in mask	<input type="checkbox"/>	Water sounds coming from the machine
<input type="checkbox"/>	Noise from mask	<input type="checkbox"/>	Noise from connectors	<input type="checkbox"/>	Loud and/or strange machine noises
<input type="checkbox"/>	Still snoring	<input type="checkbox"/>	Still sleepy during the day	<input type="checkbox"/>	Still having sleep disruption at night
<input type="checkbox"/>	Problem with tubing	<input type="checkbox"/>	Problem with humidifier	<input type="checkbox"/>	Lack of CPAP maintenance/upkeep
<input type="checkbox"/>	Old/broken tubing	<input type="checkbox"/>	No clinic followup	<input type="checkbox"/>	Insufficient CPAP provider support
<input type="checkbox"/>	"Something about me has changed that has resulted in a change in my CPAP needs." Please list what changes have taken place: _____				
<input type="checkbox"/>	"My bed partner is noticing that . . . _____"				
<input type="checkbox"/>	"I don't really know what is wrong; all I know is that I hate this thing."				
<input type="checkbox"/>	Please list any other problems you're aware of: _____				

Have you ever had snoring or sleep apnea **surgery**? YES NO

(If yes, please **make sure** surgery types, dates, and locations are written on page 5 of your questionnaire.)

Have you ever had an **oral airway dilating device (OAD)** made for your sleep apnea? YES NO

Has your **insurance company** told you that another sleep study is required? YES NO

Please arrange to have all records from your previous sleep center(s) sent to our sleep center for physician review prior to your initial clinic visit. The most crucial document is the diagnostic sleep study interpretation report, which includes the study date and your apnea hypopnea index (AHI) determined during that testing. Any additional information, such as from your CPAP provider service, would be appreciated and very helpful to us.