

Practice restricted to Orofacial Pain, Temporomandibular Joint Disorders, Oral Medicine, Oral Surgery, & Dental Sleep Medicine

Medical History Questionnaire

Snoring and Obstructive Sleep Apnoea

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:	Male <input type="checkbox"/> Female <input type="checkbox"/>
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:	

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 <input type="checkbox"/>	Mild <input type="checkbox"/>	Sore Throat <input type="checkbox"/> Daytime Drowsiness <input type="checkbox"/>
Irregular <input type="checkbox"/>	Moderate <input type="checkbox"/>	Depression <input type="checkbox"/> Waking Tiredness <input type="checkbox"/>
	Severe <input type="checkbox"/>	Irritability <input type="checkbox"/> Loss of Libido <input type="checkbox"/>
		Weight Gain <input type="checkbox"/> Poor Memory/Concentration <input type="checkbox"/>
What is your usual sleeping position? Lateral (on side)___ Supine (on back)___ Prone (on stomach)___		
Are you a smoker? Y N (Please circle)		Please tick if you have:
Do you have a gag reflex? <input type="checkbox"/> <input type="checkbox"/> Mild Moderate Heavy		
Do you wear dentures or plates? <input type="checkbox"/> <input type="checkbox"/> Mild Moderate Strong		
		Nasal Blockage <input type="checkbox"/>
		Permanent <input type="checkbox"/>
		Occasional <input type="checkbox"/>

Please list all health practitioners (including Complimentary 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 for your consultation.

MEDICAL – DENTAL

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Have you had or do you currently have any of the following conditions?

<u>Please tick either 'Yes' or 'No'</u>	Yes	No
Adenoids, tonsils removed.....		
Anaemia.....		
Bleeding disorder.....		
Bruise easily.....		
Chemotherapy.....		
Cold hands and feet.....		
Diabetes.....		
Emphysema.....		
Excessive thirst.....		
Fluid retention.....		
Hearing impairment.....		
Heart disease.....		
Heart palpitations.....		
Heart valve replacement.....		
Hepatitis.....		
Injury to neck face, head, jaw, mouth or teeth.....		
Intestinal problems.....		
Kidney problems.....		
Muscle aches.....		
Muscle tremors.....		
Neuralgia.....		
Osteoporosis.....		
Prior or current orthodontic treatment.....		
Rheumatic fever.....		
Shortness of breath.....		
Slow healing sores.....		
Speech difficulties.....		
Swollen, stiff or painful joints.....		
Tuberculosis.....		
Urinary disorders.....		
Enuresis (bed wetting).....		

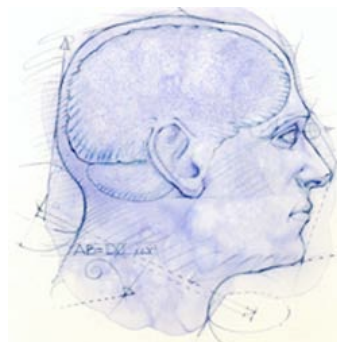
<u>Please tick either 'Yes' or 'No'</u>	Yes	No
Addison's disease.....		
Asthma.....		
Blood pressure high / low.....		
Cancer.....		
Chronic fatigue.....		
Depression.....		
Dizziness.....		
Epilepsy.....		
Extra pillows to help sleep.....		
Frequent cough.....		
Heart murmur.....		
Heart attack.....		
Heart pacemaker.....		
Haemophilia.....		
HIV.....		
Insomnia.....		
Jaw surgery.....		
Liver disease.....		
Muscle spasms and cramps.....		
Nervousness.....		
Osteoarthritis.....		
Poor circulation.....		
Radiation therapy.....		
Rheumatoid arthritis.....		
Sinus problems.....		
Skin disorders.....		
Stroke.....		
Tendency for recurrent frequent colds/flu, ear infections, or sore throats.....		
Tumours.....		
Wisdom teeth extraction.....		
Reflux.....		

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

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

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

On opening or yawning? Yes No Clench your teeth? Yes No Sometimes

On closing? Yes No Grind your teeth? Yes No Sometimes

When chewing? Yes No

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

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): _____

In this section, describe your likelihood of falling asleep in the corresponding situations.					In this section, describe your level of alertness 'right now' as you complete this form	
Epworth Scale	Likelihood of falling asleep				Karolinska Scale	
	0 = Never; 1 = Sometimes; 2 = Likely; 3 = Highly Likely					
	0	1	2	3	1 _ Very Alert	
Sitting Reading	–	–	–	–	2 _	
Watching TV	–	–	–	–	3 _ Alert	
Sitting Inactive in Public Place	–	–	–	–	4 _	
Passenger in Car (1 hour)	–	–	–	–	5 _ Neither alert nor sleepy	
Lying Down Rest Afternoon	–	–	–	–	6 _	
Sitting Talking	–	–	–	–	7 _ Sleepy but not fighting sleep	
Sitting After Lunch (No Alcohol)	–	–	–	–	8 _	
Car While Stopped (3 minutes)	–	–	–	–	9 _ Very sleepy, fighting sleep	

What is it about your snoring or sleep apnoea that you feel is important to you? (Please number in order any that apply):

Completely rid me of the sound of snoring___ A better nights sleep___ Improved health benefits___ Give me more energy___ Make my partner happy___ Help me prevent a heart attack or stroke___ Help me lose weight___ Reduce my headaches___ Improve my concentration___ Keep me awake whilst driving___

Other___ please describe_____

MEDICAL – DENTAL

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Please read the Patient Declaration.

Patient Declaration MHQ – Medical History Questionnaire OSA – Obstructive Sleep Apnea OAT – Oral Appliance Therapy	Clinical Assessment	
<ul style="list-style-type: none"> I understand that Dr Tony Eldridge is neither a medical specialist nor a medical sleep physician, but rather 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 by a dentist 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 practitioner 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, 2 and 3 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	
	ESS and KSS <input type="checkbox"/> ESS < 10 or KSS < 7 <input type="checkbox"/> ESS > 10 or KSS > 7 <input type="checkbox"/> ESS =>15 or KSS = 9	Class I OAT suitable as first line treatment. CPAP or other treatments do not appear to be necessary. Doctor Initial____ Patient Initial____
	BMI <input type="checkbox"/> BMI < 30kg/m ² <input type="checkbox"/> BMI ± 35kg/m ² <input type="checkbox"/> BMI > 40kg/m ²	Class II OAT suitable as first line treatment. Other treatments such as surgery may be required as an adjunct. Doctor Initial____ Patient Initial____
	Flemons Predictor <input type="checkbox"/> Low < 43 cm <input type="checkbox"/> Mod > 43 cm < 48 cm <input type="checkbox"/> High > 48	Class III OAT not indicated as first line treatment. Surgery, CPAP or other treatments should be instigated as 1 st choice. OAT may be considered as an adjunct on review of other treatments. Doctor Initial____ Patient Initial____
	Sleep Study Diagnosis Mild OSA Moderate OSA Severe OSA	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 1 st line treatment. Doctor Initial____ Patient Initial____
Acoustic Reflection Diagnosis <input type="checkbox"/> Nil Change <input type="checkbox"/> Minimal Change <input type="checkbox"/> Good Improvement <input type="checkbox"/> Excellent Improvement	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 1 st line treatment. Doctor Initial____ Patient Initial____	
Name: _____ Signature: _____ Date____/____/____ Dr Tony Eldridge Signature Date____/____/____		