TMJ Pain Solutions, SC
Snoring and Sleep Apnea Questionnaire

Name________________________________ DOB ____________DOS__________

CC:____

REVIEW OF SYSTEMS: Please Circle any that apply to your past or current health condition:

System	Examples
Constitutional	Weight loss/gain, fatigue, changes in sleep patterns, fever, recent trauma, unusual swelling or lumps, weakness, memory issues
Eyes	Vision changes, eye pain, double vision, light sensitivity, glaucoma
Ear, Nose, Nose, Throat, Mouth	Frequent nose bleeds, nasal congestion, sinus pain, stuffy ears, ear pain, ringing in ears, vertigo, bleeding gums, tooth pain, pain/difficulty swallowing
Cardiovascular	Chest pain, shortness of breath, palpitations, feeling faint, swelling in legs/feet, heart murmur, stroke, heart attack, HBP, high cholesterol
Respiratory	Cough, shortness of breath, asthma, emphysema, pneumonia hx, TB, snoring, sleep apnea
Gastrointestinal/Stomach	Nausea/ vomiting, reflux, ulcers, pain, Crohn's, gluten intolerance, Colitis
Genitourinary	Pregnancy 1st, 2nd,3rd Tri, birth control, menopause, hysterectomy, prostate issues, waking frequently to urinate, bladder issues, kidney stones
Musculoskeletal	Joint swelling, muscle/joint stiffness, joint disfiguration, pain, arthritis, fibromyalgia, Lyme's disease
Integumentary/Skin	Rashes, lesions, open wounds, eczema, excessive dryness, changes in size/color of mole
Neurological	Changes in sight/smell/taste, seizures, fainting/dizziness, headaches, migraines, numbness/tingling, limb weakness, speech problems, coordination issues, epilepsy, MS, Parkinson's, concussion/ TBI
Psychiatric	Depression, anxiety, bipolar disorder, ADHD, suicidal ideation, anger, work or school performance issues, worry, panic, mood changes
Endocrine	Diabetes, hypothyroid, hyperthyroid, Graves disease, adrenal insufficiency, hot/cold intolerance, abnormal weight loss/gain, excessive thirst
Hematologic/Lymphatic	Bruises easily, excessive bleeding, family hx hemophilia, hx blood transfusion, HIV, hepatitis, blood thinners
Allergic/ Autoimmune	Seasonal allergies, food, latex, materials, animals, RA, Lupus, Cancer________________, Other________________

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Family History: Please check if any family member has or has had the following:

- ☐ Loud Snoring
- ☐ Sleep apnea
- ☐ Heart Attack
- ☐ Stroke
- ☐ Migraines
- ☐ Cancer
- ☐ Diabetes

PAST MEDICAL HISTORY:

Previous Surgeries: List all surgeries, including dates:______________________________

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List all medications taken, including over the counter, and the dose

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Medication Allergies (Please list medication and reaction)______________________________

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Have you had a sleep study in the past? Yes No

If Yes, sleep lab location and approximate date ______________________________

Were you diagnosed with apnea? Yes No

Check any treatments you have tried for your snoring or sleep apnea

- ☐ CPAP
- ☐ Weight loss
- ☐ Surgery (UPPP)
- ☐ Changing sleep positions
- ☐ Oral appliances
- ☐ Other____________

Habits:

1. Do you smoke? Y N
2. Drink Alcoholic beverages Y N Quantity ______ per day/ week
3. Caffeine containing beverages? Y N Quantity ______ per day/ week

Sleep Habits:

1. How loud is your snoring None mild moderate Loud
2. Can the snoring be heard outside your bedroom with the door shut? Y N
3. Does the snoring disturb the sleep of those around you? Y N
4. Do you use medication to get to sleep? Y N

Epworth Sleepiness Scale	No Chance	Slight Chance	Moderate Chance	High Chance
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (theater/meeting)	0	1	2	3
Riding as a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car while stopped in traffic	0	1	2	3

Total ____________

Lifestyle:

1. Do you ever become drowsy while driving? Y N
2. Do you hold a CDL/Pilot's License Y N
3. Does your fatigue prevent you from doing normal activities Y N

Patient/ Guardian Signature ______________________________