

Consult & RUL Questionnaire

Patient Name:

DOB:

Date:

• Treatment in Use:

No treatment

Oral appliance

Combination therapy:
Select all that apply: Oral appliance CPAP Inspire Positional device

Hybrid therapy (oral appliance with CPAP mask interface)

Oral appliance for travel only. CPAP user

CPAP only

Other (describe)

Signs And Symptoms - Snoring:

Do you snore Yes No

<u>Rate your snoring:</u>	<u>What aggravates your snoring?</u>	<u>What relieves your snoring?</u>	<u>Do you experience other related symptoms?</u>
<input type="checkbox"/> Unknown <input type="checkbox"/> No Snoring <input type="checkbox"/> Heavy Breathing <input type="checkbox"/> Light Snoring <input type="checkbox"/> Moderate Snoring <input type="checkbox"/> Heavy Snoring	<input type="checkbox"/> Nothing <input type="checkbox"/> Supine Sleep <input type="checkbox"/> Alcohol <input type="checkbox"/> Weight Gain <input type="checkbox"/> Sinus and/or Allergy <input type="checkbox"/> Prescription Meds <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	<input type="checkbox"/> Nothing <input type="checkbox"/> Lateral Sleep <input type="checkbox"/> Avoidance of Alcohol <input type="checkbox"/> Weight Loss <input type="checkbox"/> Sinus and Allergy Management <input type="checkbox"/> Avoidance of Prescription Medications <input type="checkbox"/> Elevation of Head <input type="checkbox"/> Oral Appliance <input type="checkbox"/> Unknown <input type="checkbox"/> CPAP <input type="checkbox"/> Other: _____	<input type="checkbox"/> None <input type="checkbox"/> Witnessed Apnea <input type="checkbox"/> Gasping <input type="checkbox"/> Choking

Does your snoring affect others? Yes No

Positional Therapy:

Positional therapy is the use of a device that discourages sleeping on your back, thereby encouraging side or stomach sleep.

I have tried positional therapy

Did you have any of the following issues when utilizing positional therapy?

- I sleep on my back and cannot tolerate side sleeping only
- The positional device does not help as I am still snoring, gasping, choking or sleepy
- The positional device disturbs my sleep
- The positional device does not stay in place

I have not tried positional therapy, but refuse to use it and would prefer to try oral appliance therapy

Reasons for not trying:

- I experience pain/discomfort and as a result I shift sleep positions during sleep
- I snore, gasp and/or choke while sleeping on my side in addition to my back
- I sleep on my back and cannot tolerate sleeping on my side exclusively
- Other reason for not trying: _____

I utilize positional therapy at night while sleeping.

Oral Appliance Therapy:

I have an oral appliance for a sleep related breathing disorder such as sleep apnea or snoring?

Year the appliance was obtained: _____ Was it covered by medical insurance? _____

I am experiencing issues with my oral appliance.

- Pain/Discomfort
- Bite Changes/Tooth Movement
- Fracture
- Delamination
- Retention
- Hardware Problem
- Dental Work Completed
- Dog Damaged Appliance
- Appliance Lost
- No Further Protrusive Movement Available
- Other: _____

I use my oral appliance while I sleep.

Average number of hours of use per night? _____

Average number of days per week the appliance is used? _____

- I use the morning repositioner exercise mouthpiece.

While I do not currently have an oral appliance, I have had an oral appliance in the past for sleep apnea or snoring.

Year the appliance was obtained: _____ Was it covered by medical insurance? _____

Positive Airway Pressure (PAP):

Is a CPAP, Auto PAP or Bi-PAP Machine used presently?

Yes No

If Yes:

Number of days per week? _____

Number of hours per night? _____

What type of machine:

CPAP

BiPAP

Auto-PAP (APAP)

Adaptive Servoventilation (ASV)

Was it used with heated humidification?

Yes

No

What style(s) of mask have you tried?

Nasal pillows

Nasal mask

Full face mask

If No:

Was PAP tried at any point?

Yes

No

Positive Airway Pressure Complaints: (please select all that apply)

- Mask leaks
- An inability to identify a mask that fits properly
- Discomfort caused by the straps and headgear
- Disturbed or interrupted sleep caused by the presence of the device
- Noise from the device disturbs sleep or bed partner's sleep
- Restricted movements during sleep
- Does not seem to be effective
- Pressure on the upper lip causes tooth related problems
- Claustrophobic associations
- Unconscious need to remove device overnight
- Other
- My physician recommended oral appliance as opening treatment

Surgery:

Has the Inspire Implant been recommended? Yes No

If Yes: Was the surgery completed? Yes No

Have any sleep studies been performed since the surgery? Yes No

Has an effective setting been identified for inspire? Yes No

If No: Somewhat effective Apnea treated but residual symptoms Unknown

Days Inspire used per week (on average)? _____

Hours Inspire used per night (on average)? _____

Has surgery been recommended for a sleep related breathing disorder? Yes No

If Yes: What type of surgery was recommended? Bariatric surgery Upper airway surgery Other: _____

Was surgery completed? Yes No

Weight:

- | |
|---|
| <input type="checkbox"/> I have experienced weight gain over the past 12 months |
| <input type="checkbox"/> I have experienced weight loss over the past 12 months |
| <input type="checkbox"/> I have attempted to change my eating habits |
| <input type="checkbox"/> I have participated in an exercise program |

Current Medication:

- | |
|---|
| <input type="checkbox"/> I take medications |
|---|

Medication Name:

Purpose:

Medical History:

Medical Conditions (Alphabetical Order)

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Asthma
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Cancer
<input type="checkbox"/> Chest pain / Angina	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> COPD (lung condition)
<input type="checkbox"/> Coronary Heart / Artery Disease	<input type="checkbox"/> Depression	<input type="checkbox"/> Difficulty focusing / concentrating
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> GERD / Reflux / Heartburn	<input type="checkbox"/> Heart Attack / Myocardial Infarct
<input type="checkbox"/> High Blood Pressure / Hypertension	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Hypothyroid (Hashimoto's)
<input type="checkbox"/> Implantable Cardioverter Defibrillator (ICD)	<input type="checkbox"/> Infections Disease: _____	<input type="checkbox"/> Injury to head, neck, jaw
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Memory Impairment (e.g., Dementia)	<input type="checkbox"/> Migraine headache	<input type="checkbox"/> Nasal fracture
<input type="checkbox"/> No medical history	<input type="checkbox"/> Orthodontics	<input type="checkbox"/> Osteoporosis / Osteopenia
<input type="checkbox"/> Other medical equipment: _____	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Poor hand strength
<input type="checkbox"/> Restless Leg Syndrome	<input type="checkbox"/> Seasonal/Environmental allergies	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Sickle cell anemia	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Stroke, CVA, or TIA
<input type="checkbox"/> Type II Diabetes	<input type="checkbox"/> Other: _____	

Allergies/Intolerance:

Reaction:

<input type="checkbox"/> Nickel	
<input type="checkbox"/> Mint	
<input type="checkbox"/> Latex	
<input type="checkbox"/> Other Allergies (list):	

Surgical History:

Tonsils Adenoids Uvula Sinus Soft Palate Deviated Septum Inspire Implant

Other surgeries:

Hospitalization:

List any other than those associated with surgical history:

Family History:

Father

- Alive Deceased Unknown
- Diabetes
- Atrial Fibrillation/Arrhythmia
- Heart Disease: (Congestive Heart Failure, Coronary Heart /Artery Disease, Heart Attack/Myocardial Infarction)
- Hypertension
- Stroke/TIA
- Snoring
- Sleep Apnea

Mother

- Alive Deceased Unknown
- Diabetes
- Atrial Fibrillation/Arrhythmia
- Heart Disease: (Congestive Heart Failure, Coronary Heart /Artery Disease, Heart Attack/Myocardial Infarct)
- Hypertension
- Stroke/TIA
- Snoring
- Sleep Apnea

Social History:

Do you use alcohol? Yes No

How often: Daily Weekly Monthly Yearly

How many servings: _____

Tobacco Use: Current Former Never

If current:

How many cigarettes a day do you smoke? _____

How often do you smoke cigarettes? _____

If former:

How long has it been since you last smoked? _____

Do you use caffeine? Yes No

How often: Daily Weekly Monthly Yearly

How many serving: _____

Do you use any recreational drugs? Yes No

Review of Systems:

Dental:

Periodontal Disease? Yes No

If yes:

Severity: Mild Moderate Severe

Status: Managed Not Managed

Hygiene visit in past 6 months? Yes No

Recommended/planned/incomplete dental work? Yes No

If yes, please explain:

Musculoskeletal

Current/Recent Temporomandibular Joint (TMJ) Pain? Yes No

If yes (select all that apply):

Status: Treated Untreated

Severity: Mild Moderate Severe

Since wearing the appliance jaw pain has:

Improved

Not Changed

Become Worse

Psychology

Irritability: Yes No