Name_____ Date_____

CHIEF COMPLAINTS/TREATMENT HISTORY

What are the **chief complaints** for which you are seeking treatment?

☐ CPAP intolerance
☐ Difficulty falling asleep
☐ Fatigue
☐ Frequent heavy snoring
☐ Frequent heavy snoring which affects the sleep of others
☐ Gasping when waking up
☐ Night-time choking spells
☐ Significant daytime drowsiness
☐ Sleepiness while driving
☐ Witnessed apneic events
☐ Other (please write in) _____

Are you a **current** CPAP (Continuous Positive Air Pressure) user? Y N How long?_____
If yes, what are the current CPAP settings? _____
If no, did you ever try the CPAP? Y N

CPAP Intolerance

If you have attempted treatment with a CPAP device, but could not tolerate it, please fill in this section

☐ Mask leaks
☐ Inability to get the mask to fit properly
☐ CPAP does not seem to be effective
☐ Discomfort from headgear
☐ Latex allergy
☐ Cumbersome
☐ Claustrophobic associations
☐ CPAP restricted movement during sleep
☐ An unconscious need to remove the CPAP
☐ Does not resolve symptoms
☐ Pressure on the upper lip causing tooth-related problems
☐ Disturbed or interrupted sleep
☐ Noise disturbing sleep and/or bed partner's sleep
☐ Other _____

Other Therapy Attempts

☐ Dieting/weight loss
☐ Pillar procedure
☐ CPAP
☐ Surgery (Uvulectomy, uvuloplasty, UPPP, etc.)
☐ Smoking cessation
☐ BiPAP
☐ Positional therapy (pillows, tennis balls, Rematee, etc.)
☐ Other (please describe) _____

History of Treatment

Practitioner's name	Specialty	Treatment	Date of Treatment

CC 07312014

Family history:
Has any member of your family had:

☐ Obstructive Sleep Apnea? Family member(s)_____
☐ Cardiovascular/heart disease? Family member(s)_____
☐ Stroke/TIA? Family member(s)_____
☐ Diabetes? Family member(s) _____
☐ Asthma/pulmonary/respiratory? Family member(s) _____