Dr. Hitesh Patel

PRE-TREATMENT QUESTIONNAIRE

Please fill out this page and the information will help us quickly understand your needs and in the process provide you with excellent patient-focused service. Our patients have found that filling out this form helps them to think about what they want out of their visit and how we can help in the best way possible. So, grab a pen and let us know more about you!

I decided to make an appointment because _____

_____

My biggest concern is _____

_____

My health goals for the future are. _____

_____

I would like to learn more about _____

Once I have completed my visits I'm looking forward to _____

_____

I'm having pain or discomfort ☐ YES NO ☐

If your answer is YES, please answer these two questions:

I have the following kind of pain _____

_____

How do you rate your pain from 0 to 10 (0 is NO PAIN and 10 is MOST SEVERE PAIN): _____

When I'm free of pain I will be able to _____

How do you want your quality of life to change? _____

Patient Name: _____ Date: _____

Patient Signature: _____

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Sleep Screening Questionaire

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

Today's Date:

Patient Information

NAME: ☐ Mr. ☐ Ms. ☐ Miss ☐ Mrs. ☐ Dr. _____ _____ _____

First Middle Initial Last

AGE: _____ BIRTH DATE: _____ ☐ Male ☐ Female SS#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYED BY: _____

EMPLOYER'S ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE : _____

EMAIL: _____ RESPONSIBLE PARTY: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

FAMILY PHYSICIAN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

FAMILY DENTIST: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HEIGHT: _____ WEIGHT: _____ REFERRED BY: _____

Please list other health care practitioners seen in the last 9 months:

Insurance

MEMBER NUMBER: _____ GROUP NUMBER: _____

PLAN NUMBER: _____ PRIMARY CARE PHYSICIAN: _____

What are the chief compaints for which you are seeking treatment?

Please number the complaints with #1 being the most important.

_____ Frequent heavy snoring which affects the sleep of others.
_____ Significant daytime drowsiness
_____ I have been told that I stop breathing when sleeping.
_____ Difficulty falling asleep
_____ Gasping when waking up
_____ Nighttime choking spells
_____ Feeling unrefreshed in the morning
_____ Morning hoarseness
_____ Morning headaches
_____ Swelling in ankles or feet
_____ Nocturnal teeth grinding
_____ Jaw pain
_____ Facial pain
_____ Jaw clicking
_____ Other _____

IN CASE OF EMERGENCY PLEASE CONTACT: _____

Patient Signature: _____ Date: _____

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Patient Signature: _____ **DOB:** _____ **DOS:** _____

Health Questions *(Please answer the best you can)*		
Are you unable to sleep in a flat position due to shortness of breath?	☐ Yes	☐ No
Do you have a family history of snoring or other sleep disorders?	☐ Yes	☐ No
If yes, please describe:		
Have you ever sustained a brain concussion, head injury or serious blow to the head?	☐ Yes	☐ No
Do you have dizzy spells or seizures?	☐ Yes	☐ No
Do you have high blood pressure?	☐ Yes	☐ No
Have you experienced a weight gain in the last year?	☐ Yes	☐ No
if yes, how much weight?		
Has your shirt collar size increase recently?	☐ Yes	☐ No
if yes, by how much?		
Do you smoke?	☐ Yes	☐ No
How many packs per day? How long have you smoked?		
Have you quit smoking?	☐ Yes	☐ No
How many packs per day prior to quitting? How long did you smoked? Year quit?		
Do you drink alcohol?	☐ Yes	☐ No
If yes, please estimate the number of drinks per day. (beer, wine, or liquor)		
Do you drink caffeinated drinks?	☐ Yes	☐ No
If yes, please estimate the number of drinks per day. (sodas, coffee, or tea)		
(Female) Have you gone through menopause?	☐ Yes	☐ No
(Males) Have you experience any prostate issues? (i.e. Frequent urination)	☐ Yes	☐ No

Sleep Health Concerns & Habits

Describe your sleep problem(s) in your own words.

Describe how and when this problem began.

Describe any treatments you have received for your problem.

Has this been a continuous problem? ☐ Comes and goes ☐ Occasional ☐ Frequent ☐ Constant

How long has your sleep problem bothered you? ☐ Greater than 2 yrs. ☐ 1-2 yrs. ☐ Several Months ☐ Last 3 Months ☐ Within the Month

What time do you usually go to bed? _____ Weekdays: _____ Weekends: _____

What time do you usually wake up? _____ Weekdays: _____ Weekends: _____

How many hours of sleep do you usually get per night? _____

How long does it take you to fall asleep? _____

If you awake in the middle of the night, how long are you typically awake for? _____

Which shift do you work? (Check all that apply) ☐ Day ☐ Evening ☐ Night

Sleep Questions	**Never**	**Rarely**	**Often**	**Frequent**	**Always**
How often do you rotate shifts?	☐	☐	☐	☐	☐
Does your job require overnight travel?	☐	☐	☐	☐	☐
Do you drink alcohol after 6pm?	☐	☐	☐	☐	☐
Do you drink caffeinated beverages after noon?	☐	☐	☐	☐	☐
Do you suffer from a loss of libido?	☐	☐	☐	☐	☐
(Males) Have you experienced difficulties with sexual functions?	☐	☐	☐	☐	☐

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Patient Signature: _____ DOB: _____ DOS: _____

Sleep Questions	Never	Rarely	Often	Frequent	Always
(Females) Does your sleep problem vary according to the stage of your menstrual cycle?	☐	☐	☐	☐	☐
(Females) Have you gone through menopause or had a hysterectomy?	☐	☐	☐	☐	☐
Are you able to fall asleep and awaken on a daily, weekly basis according to your desired schedule?	☐	☐	☐	☐	☐
Do you nap during the day or evening?	☐	☐	☐	☐	☐
Do you feel refreshed after sleeping?	☐	☐	☐	☐	☐
Do you feel sleepy during the day even when you have slept all night?	☐	☐	☐	☐	☐
Do you feel refreshed after a short nap?	☐	☐	☐	☐	☐
Do you get sleepy while driving?	☐	☐	☐	☐	☐
Have you had an accident or near-accident when driving, due to excessive sleepiness?	☐	☐	☐	☐	☐
Do you fall asleep when you want to stay awake (movies, theater, church, or watching television)?	☐	☐	☐	☐	☐
Are you able to fight off the excessive sleepiness?	☐	☐	☐	☐	☐
Do you have memory or concentration problems?	☐	☐	☐	☐	☐
Do you experience vivid dream-like scenes upon awakening or falling asleep?	☐	☐	☐	☐	☐
When you are angry or laugh, do you ever feel weak, as though you might fall?	☐	☐	☐	☐	☐
Are you ever unable to move or speak upon falling asleep or awakening?	☐	☐	☐	☐	☐
Do you have trouble falling asleep when you go to bed?	☐	☐	☐	☐	☐
When you try to fall asleep does your mind race with thoughts?	☐	☐	☐	☐	☐
When you try to fall asleep do you feel pain?	☐	☐	☐	☐	☐
Does pain ever wake you up, disrupt your sleep or keep you from going back to sleep?	☐	☐	☐	☐	☐
Are you a light sleeper, easily awakened?	☐	☐	☐	☐	☐
Is your sleep disrupted because of your- bed partner or others in your household?	☐	☐	☐	☐	☐
Do you snore?	☐	☐	☐	☐	☐
Does your snoring stop for brief periods during sleep?	☐	☐	☐	☐	☐
Does your breathing sometimes stop during sleep?	☐	☐	☐	☐	☐
Is your bed partner disturbed by your snoring?	☐	☐	☐	☐	☐
Do you wake up choking or gasping for breath?	☐	☐	☐	☐	☐
Do you have night sweats?	☐	☐	☐	☐	☐
Do you have heartburn at night?	☐	☐	☐	☐	☐
Do you have a bitter bile taste in the back of your throat when you wake up (not "morning breath")?	☐	☐	☐	☐	☐
Do you have nasal / sinus congestion at night?	☐	☐	☐	☐	☐
Do you have morning headaches?	☐	☐	☐	☐	☐
Are you a restless sleeper, tossing and turning at night?	☐	☐	☐	☐	☐
Do you have a creeping or crawling sensations in you legs when you lie down to sleep?	☐	☐	☐	☐	☐
Do you experience any type of leg or back pain during the night?	☐	☐	☐	☐	☐

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Berlin Questionnaire Sleep Evaluation

1. Complete the following:

☐ height ☐ age

☐ weight ☐ male ☐ female

2. Do you snore?

- ☐ yes
- ☐ no
- ☐ don't know

If you snore:

3. Your snoring is?

- ☐ slightly louder than breathing
- ☐ as loud as talking
- ☐ louder than talking
- ☐ very loud. Can be heard in adjacent rooms

4. How often do you snore?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ never or nearly never

5. Has your snoring ever bothered other people?

- ☐ yes
- ☐ no

6. Has anyone noticed that you quit breathing during your sleep?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

7. How often do you feel tired or fatigued after you sleep?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly

8. Have you ever nodded off or fallen asleep while driving a vehicle?

- ☐ yes
- ☐ no

if yes, how often does it occur?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

Category 2

9. Do you have high blood pressure?

- ☐ yes
- ☐ no
- ☐ don't know

Category 3

(For office use)

Scoring Questions:	Any answer within the box outline is a positive response.
Scoring Categories:	Category 1 is positive with 2 or more positive responses to questions 2-6 Category 2 is positive with 2 or more positive responses to questions 7-9 Category 3 is positive with t positive responses and/or a BMI>30 (BMI- Body Mass Index)
Final Results:	2 or {more possible categories indicates a high likelihood of steep disordered breathing.

Patient Signature: _____ **Date:** _____

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Patient Signature: _____ **Date:** _____

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to assess a person daytime sleepiness.
How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to your usual way of life in recent times.

Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:
0 = would **never** doze or sleep.
1 = **slight** chance of dozing or sleeping
2 = **moderate** chance of dozing or sleeping
3 = **high** chance of dozing or sleeping

Situation	**Chance of Dozing**
Sitting and Reading?	
Watching TV?	
Sitting inactive in a public place (ex: meeting, theater)?	
Being a passenger in a motor vehicle for an hour or more?	
Lying down to rest in the afternoon if circumstances permit?	
Sitting and talking to someone?	
Sitting quietly after lunch without alcohol?	
In a car, while stopped for a few minutes in traffic?	
Total:	

Thank You!

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CPAP INTOLERANCE AFFIRMATION SHEET

Patient Name: _____

I, _____ make my statement and General Affidavit upon oath and affirmation of belief and personal knowledge that the following matters, facts, and things set forth are true and correct to the best of my knowledge.

I have been prescribed the nasal CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis due to the following reason (s):

- ☐ Mask Leaks
- ☐ Mask is uncomfortable / device is uncomfortable
- ☐ Unable to sleep comfortably
- ☐ Noise disturbs sleep and / or bed partners sleep
- ☐ Movement is restricted during sleep
- ☐ Does not seem to be effective
- ☐ Straps/ Headgear cause discomfort
- ☐ Pressure in the upper lip caused tooth related problems
- ☐ Latex allergy
- ☐ Claustrophobia
- ☐ Other _____

Because of my intolerance / inability to use the CPAP, I wish to have an alternative method of treatment. The method of treatment is an Oral Airway Dilator Appliance, as prescribed to me by:

Dr. _____

_____ _____

Patient Signature Witness Signature

Date: _____

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List any medications/substances which have caused an allergic reaction:

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Barbiturates
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Other: _____

List any medications currently being taken:

Y☐ N☐ Antibiotics
Y☐ N☐ Anticoagulants
Y☐ N☐ Barbiturates
Y☐ N☐ Blood thinners
Y☐ N☐ Codeine
Y☐ N☐ Other: _____
Y☐ N☐ Cortisone
Y☐ N☐ Diet pills
Y☐ N☐ Heart medication
Y☐ N☐ Insulin
Y☐ N☐ Muscle relaxants
Y☐ N☐ Nerve pills
Y☐ N☐ Pain medication
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Tranquilizers

Please list all treatments and health professionals that you are currently seeing or have seen for this problem:

PRACTITIONER: _____ MD/DDS SPECIALTY _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE NUMBER: _____

DIAGNOSIS/TREATMENT: _____

DATES OF TREATMENT: _____

PRACTITIONER: _____ MD/DDS SPECIALTY _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE NUMBER: _____

DIAGNOSIS/TREATMENT: _____

DATES OF TREATMENT: _____

Patient Signature: _____ Date: _____

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Medical history:

(Please indicate dates on questions checked YES)

Y☐ N☐ Adenoids Removed
Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Blood Pressure
☐ High ☐ Low
Y☐ N☐ Bruising easily
Y☐ N☐ Frequent cough
Y☐ N☐ Frequent illnesses
Y☐ N☐ Frequent stressful situations
Y☐ N☐ Fibromyalgia
Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to
☐ Face ☐ Neck ☐ Head
☐ Mouth ☐ Teeth
Y☐ N☐ Insomnia
Y☐ N☐ Intestinal disorders
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Kidney problems
Y☐ N☐ Liver disease
Y☐ N☐ Meniere's disease
Y☐ N☐ Menstrual cramps
Y☐ N☐ Multiple sclerosis
Y☐ N☐ Muscle aches
Y☐ N☐ Muscle shaking (tremors)
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Muscular dystrophy
Y☐ N☐ Needing extra pillows to help breathing at night

Y☐ N☐ Current pregnancy
Y☐ N☐ Depression
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Excessive thirst
Y☐ N☐ Fluid retention
Y☐ N☐ Heart palpitations
Y☐ N☐ Heart valve replacement
Y☐ N☐ Hemophilia
Y☐ N☐ Hepatitis
Y☐ N☐ Nervous system irritability
Y☐ N☐ Nervousness
Y☐ N☐ Neuralgia
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Ovarian cysts
Y☐ N☐ Parkinson's disease
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Psychiatric care
Y☐ N☐ Radiation treatment
Y☐ N☐ Rheumatic fever
Y☐ N☐ Rheumatoid arthritis
Y☐ N☐ Scarlet fever
Y☐ N☐ Shortness of breath
Y☐ N☐ Sinus problems
Y☐ N☐ Skin disorder
Y☐ N☐ Slow healing sores

Y☐ N☐ General anesthesia
Y☐ N☐ Glaucoma
Y☐ N☐ Gout
Y☐ N☐ Hay fever
Y☐ N☐ Hearing impairment
Y☐ N☐ Heart disorder
Y☐ N☐ Heart murmur
Y☐ N☐ Heart pacemaker
Y☐ N☐ Cancer
Y☐ N☐ Chemotherapy
Y☐ N☐ Chronic fatigue
Y☐ N☐ Cold hands & feet
Y☐ N☐ Hypoglycemia
Y☐ N☐ Speech difficulties
Y☐ N☐ Stroke
Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Tendency for:
☐ Frequent colds
☐ Ear infections
☐ Sore throats
Y☐ N☐ Tired muscles
Y☐ N☐ Tonsils Removed
Y☐ N☐ Tuberculosis
Y☐ N☐ Tumors
Y☐ N☐ Urinary disorders
Y☐ N☐ Wisdom teeth (third molar) extraction
☐ Other: _____

Patient Signature: _____ Date: _____

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Informed Patient Consent

Patient Name: _____ **DOB:** _____

Welcome! We would like to give you a little more information about ourselves, and what to expect during our sleep apnea testing & treatment process. This document contains important information about our professional services and business policies. Please read it carefully, and if you have any questions, we can discuss them together prior to starting the sleep apnea testing and treatment process. When you sign this document, it will represent an agreement between us.

CONFIDENTIALITY AND PRIVACY NOTICE;

Privacy is a very important concern for all those who use our services. In general, the privacy of all communications between a patient and a physician is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

We may need to release basic diagnostic and clinical information to your insurance provider in order to obtain treatment authorization or to get claims paid. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings, a judge may order our testimony if he/she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect you or others from harm, even if we have to reveal some information about a patients treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency, or if we believe that a patient is threatening serious bodily harm to another. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have together. If you need specific advice, please be aware that formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not-attorneys.

I have read and discussed the above agreement. I understand and agree to all of the points discussed above. If at any point I have questions or problems regarding my treatment, I understand how to contact the practice, and receive support for my individual needs, I am providing consent for treatment to include, home sleep testing, diagnostic scans such as X-ray or Cone Beam CT), and related sleep apnea treatment devices- if sleep disordered breathing is diagnosed.

Patient	Date

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1309 Macom Drive, Suite 107
Naperville, IL 60564
(630) 305-7914 • Fax (630) 305-7575
email: frontdesk@suburbantmjcenter.com

Medical Records Release Form

Patient Name: _____ **DOB:** _____

By Signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a a summary or narrative of my protected health information, to the physician/person/facility/entity listed:

Suburban TMJ and Sleep Center
1309 Macom Drive, Suite 107
Naperville, IL 60564
(630) 305-7914 • Fax (630) 305-7575
email: frontdesk@suburbantmjcenter.com

_____

Patient _____ Date _____