Rodney J. Bughao, D.D.S.
Dental Sleep Medicine | Hospital Dentistry &
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New Patient Questionnaire - Obstructive Sleep Apnea

Patient's Full Name:_____ Date: _____

Address: _____ Date of Birth: ____/____/____
Number and Street

_____ SSN: _____-____-_____
City, State, ZIP

Phone # _____ Cell #: _____ Fax #: _____

Email:_____

Contact Person (In Case Of Emergency): _____ Relationship to Pt: _____

Phone #: _____ Cell #: _____ Fax _____

Address:_____

Email:_____

Medical Insurance: _____ ID #: _____

Subscriber's Name: _____ D.O.B. ___/___/___ SSN: ___-__-____

Medicare: ___ Yes ___ No ID#: _____

Primary care physician: _____ Phone #_____

Address: _____ Fax #: _____

Name of referring specialist/physician:_____

Phone #: _____ Fax #: _____ Email: _____

Have you had a sleep study done?:_____ If yes, what type & date: _____

Name of Dentist _____(for copies of x-rays) Dentist's Phone # _____

Are you having any dental work done? _____ If so, what? _____

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SLEEP APNEA QUESTIONNAIRE

Name:	Date:	D.O.B.:
Sex:	Height:	Weight:
Neck Circumference:	Male: Greater than 17 in? Y/N	Female: Greater than 16 in? Y/N

CHIEF COMPLAINTS

Yes	No		Yes	No		Yes	No	
☐	☐	Do you snore?	☐	☐	Have you had or been treated for high blood pressure?	☐	☐	Do you feel pain in your jaw joints?
☐	☐	Do you snore only while lying on your back?	☐	☐	Do you doze off unintentionally during the day?	☐	☐	Do you grind or clench you teeth in your sleep?
☐	☐	Do you snore loudly?	☐	☐	Do you have drowsiness while driving?	☐	☐	Have you ever been diagnosed, or do you suspect you have OSA?
☐	☐	Do you snore every night?	☐	☐	Do you often wake feeling tired?	☐	☐	Have you ever been to a specialist for snoring or OSA?
☐	☐	Have you been told you stop breathing or gasp during sleep?	☐	☐	Do you often wake in the morning with a headache?	☐	☐	Have you ever had a sleep study?
☐	☐	Has your partner had to move to another room during the night?	☐	☐	Do you have problems concentrating for long periods of time?	☐	☐	Have you ever been treated for snoring, OSA, or a sleep disorder?

MEDICAL HISTORY

Please check if you have/have had any of those listed below. If yes, please explain:

Yes	No		Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	Stroke	☐	☐	Respiratory problems
☐	☐	Heart disease	☐	☐	Sleep disorder	☐	☐	Renal problems
☐	☐	Diabetes	☐	☐	Obesity	☐	☐	Digestive issues
☐	☐	High blood pressure	☐	☐	Thyroid disorder	☐	☐	Neurological issues

Please list any and all past surgeries:

_____

_____

Current Medications:	For:

OK to attach med sheet

Allergies? (Drug or Seasonal)

Have you used/are you using the CPAP machine ☐ Yes, in the past
☐ Yes, currently
☐ No

CPAP INTOLERANCE

If you have attempted the CPAP machine, but were not successful, please fill out the following section:

Yes No

☐ ☐ Mask leaks

☐ ☐ Ill-fitting mask

☐ ☐ Mask discomfort

☐ ☐ Disturbed sleep

Yes No

☐ ☐ Noise disturbing sleep

☐ ☐ CPAP restricted movements

☐ ☐ CPAP seems ineffective

Other_____

Yes No

☐ ☐ Latex allergy

☐ ☐ Claustrophobia associations

☐ ☐ Unconscious need to remove the mask

Yes No

☐ ☐ Does not resolve symptoms

☐ ☐ Burdensome

☐ ☐ Pressure on upper lip causing tooth problems