KOALA CENTER FOR SLEEP DISORDERS Patient Registration Today's Date ____________

Last Name ________________________________ First Name ________________________ Middle Initial _________

Address ____ Zip Code _____________ Sex: Male / Female

Do you live at this address for 6+ months out of the year? Yes / No If no, please provide additional address:

Address ____________________________ City, State ___________________________ Zip Code __________

Please "✓" which number is the best for you:

Home Phone _____________________ ( )

Work Phone _____________________ ( )

Cell Phone ______________________ ( )

E-mail Address: ___________________________

Marital Status:

( ) Single ( ) Married ( ) Divorced

( ) Legally Separated

Date of Birth: ______________________________

Social Security #: ___________________________

Patient's Employer: ________________________

Occupation:_____________________________

Preferred Language __________________________

Ethnicity:

( ) Hispanic or Latino ( ) Not Hispanic or Latino

( ) Unknown ( ) Decline to Answer

Race: ( ) American Indian or Alaska Native

( ) Native Hawaiian or Other Pacific Islander

( ) Black or African American ( ) Asian

( ) White ( ) Other Race ( ) Decline

Responsible Party *(if other than patient):*

Last Name __________________________ First Name ________________________ Middle Initial _________

Address ____ Zip Code _____________ Sex: Male / Female

Employer: _____________________________________ Title: _______________ DOB: ____________

Medical Insurance Information *(please bring cards so we can copy for your file)*

Primary Insurance Carrier: ____________________________ Group #: __________________________

Subscriber Name: _______________________________ Member ID: ________________________

Group Name (Employer) ___________________________ Ins Company Phone #:_________________

Relationship of Subscriber to patient: ____________________ Subscriber Birthdate: _________________

Secondary Insurance Carrier: __________________________ Group #: __________________________

Subscriber Name: _______________________________ Member ID: ________________________

Group Name (Employer) ___________________________ Ins Company Phone #:_________________

Relationship of Subscriber to patient: ____________________ Subscriber Birthdate: _________________

Referral Information: *(please be specific- name of person, physician or marketing source- list more than one if applicable)*

How did you hear about our office? ____

Which medical doctor(s) would you like us to communicate your treatment with? *Referred to us by this doctor? Y / N*

Primary Care Physician Name ________________________________ City, State ______________________ ( )

Specialist Physician Name __________________________________ City, State ______________________ ( )

KOALA CENTER FOR SLEEP DISORDERS Medical History Questionnaire

NAME: _______________________________________ DATE OF BIRTH: _________TODAY'S DATE: ___________
FIRST MIDDLE INITIAL LAST

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

PLEASE MARK ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION

( ) Codeine
( ) Iodine
( ) Barbiturates
( ) Antibiotics
( ) Aspirin
( ) Penicillin
( ) Plastic
( ) Metals
( ) Latex
( ) Local anesthetics
( ) Sulfa drugs
( ) Sedatives
( ) Sleeping pills

Other __________________________ _________________________ ______________________

LIST ANY MEDICATION CURRENTLY BEING TAKEN: *You may bring in a preprinted list if available.*

Medication name	Dosage/Frequency	Reason
____________________________	________________	_____________________________________
____________________________	________________	_____________________________________
____________________________	________________	_____________________________________
____________________________	________________	_____________________________________
____________________________	________________	_____________________________________

Height ___________ Weight___________ Neck measurement___________

Medical History

PLEASE MARK ALL THAT APPLY IN THE SECTIONS BELOW

PAST MEDICAL HISTORY:

☐ Anemia
☐ Asthma
☐ Diabetes Insulin? Y / N
Type I / II (please circle)
☐ Epilepsy
☐ Heart attack
☐ Pneumonia
☐ Tuberculosis
☐ COPD
☐ Cancer - Type_____________
Cancer Remission? Y / N
☐ Other _________________
☐ No illnesses to report

INJURIES:

☐ Arm injury
☐ Back injury
☐ Broken bone
☐ Excessive bruising
☐ Leg injury
☐ Recent fall
☐ Sprains
☐ Head and/or Neck Wounds
☐ Other_________________
☐ No injuries to report

HOSPITALIZATIONS/SURGERIES:

☐ Appendectomy
☐ Cervical spine fusion
☐ Coronary artery bypass
☐ Hysterectomy
☐ Tonsillectomy
☐ Hip replacement
☐ Knee replacement
☐ UP3
☐ Nasal surgery
☐ Other_____________________
☐ None

TREATMENTS:

☐ Chemotherapy
☐ Physical therapy
☐ CPAP, APAP, BiPAP
☐ Chiropractic
☐ Psychiatric
☐ No treatments to report
☐ Other_____________________

FAMILY HISTORY:

☐ Cancer
☐ Depression
☐ Diabetes
☐ Heart disease
☐ High blood pressure
☐ Thyroid problems
☐ Obesity
☐ Father snores
☐ Mother snores
☐ Father has/had sleep apnea
☐ Mother has/had sleep apnea
☐ Other sleep disorder
☐ Family history unknown
☐ No significant family history to report

SOCIAL HISTORY:
☐ Married ☐ Divorced ☐ Single ☐ Widowed

ALCOHOL USE:
☐ Beer ☐ Liquor ☐ Wine Drinks/week______ ☐ None

SMOKING STATUS:
☐ Current Smoker ☐ Former Smoker
Type_________ Packs/day____ Duration____
Year quit_____ ☐ Never Smoked

CAFFEINE:
Drinks/Day_____ ☐ None

EXERCISE:
☐ Yes ☐ No

RECREATIONAL DRUG USE:
☐ Yes ☐No

FOR WOMEN ONLY: Currently Pregnant? Y / N
If Yes, Due Date _________________

Peri or Post-Menopausal? Y / N
If Yes, for how many years? _____

REVIEW OF SYSTEMS
Please mark all that apply in the sections below. Thank you!

CONSTITUTIONAL:
☐ Fatigue ☐ Night sweats ☐ Weight gain ☐ Weight loss

EYES:
☐ Dry eyes ☐ Headaches ☐ Visual changes ☐ Ocular pain ☐ Itchy eyes

EAR, NOSE, MOUTH, THROAT: (*Please circle which ear you are having difficulty with.)
☐ Dry mouth ☐ Ear pain / pressure* **R L Both** ☐ Hearing loss* **R L Both**
☐ Nasal congestion ☐ Neck pain/stiffness ☐ Oral pain ☐ Sore throat
☐ Tinnitus (Ringing in the Ears)* **R L Both** ☐ Trouble swallowing

CARDIOVASCULAR:
☐ Chest pain / pressure at rest ☐ Chest pain / pressure with exertion ☐ Cold hands / feet
☐ Palpitations ☐ Syncope (Fainting) ☐ Hypertension ☐ Heart Disease

RESPIRATORY:
☐ Pain with breathing ☐ Productive cough ☐ Wheezing ☐ Asthma ☐ COPD

GASTROINTESTINAL:
☐ Abdominal pain ☐ Heartburn ☐ Hepatitis (please specify type) _________

GENITOURINARY: ☐ Blood in urine ☐ Discharge ☐ Lesions ☐ Tenderness ☐ Incontinence

MUSCULOSKELETAL: (*Please note which joint you are having difficulty with)
☐ Fractures ☐ Joint pain/any joint*________ ☐ Joint stiffness* _________________
☐ Muscle weakness ☐ Sprain* __________________
☐ Myalgia (muscle pain) ☐ Arthritis*__________________

SKIN: ☐ Dry skin ☐ Knots /Skin nodules ☐ Rashes ☐ Skin lesions ☐ Skin cancer

NEUROLOGICAL:
☐ Dizziness ☐ Gait disturbance ☐ Headache ☐ Numbness
☐ Paresthesia (prickly or numbness feeling)
☐ Speech disturbance ☐ Seizures ☐ Tingling ☐ Coordination problem
☐ Parkinson's ☐ Alzheimer's ☐ Dementia

PSYCHIATRIC:
☐ Anxious / nervous ☐ Depressed

LYMPHATIC:
☐ Anemia ☐ Bleeding tendency ☐ Lymph node pain / enlargement ☐Transfusions
☐ Thyroid Disorder

Is there any other significant medical history that is not mentioned above? ____

SLEEP HISTORY CONSULTATION

CHIEF COMPLAINTS: (*Please mark all that apply.)*

☐ CPAP, BiPAP or APAP difficulty
☐ Daytime tiredness
☐ Difficulty falling asleep
☐ Decrease in concentration
☐ Impaired Thinking Ability
☐ Gasping/Choking that wakes you
☐ Loud snoring/affecting sleep of others

☐ Never feels rested
☐ Awakes unrefreshed
☐ Sleepiness while driving
☐ You have been told you stop breathing in your sleep
☐ Not dreaming
☐ Insomnia
☐ Frequent arousal from bed

☐ Difficulty swallowing
☐ Facial pain
☐ Headaches/migraines
☐ Jaw clicking/ noise in jaw
☐ Jaw locking/limited opening
☐ Jaw pain
☐ Ear pain
☐ Ear congestion
☐ Ringing in the ears

How many times do you get up in the night? ______

SLEEP STUDY HISTORY:

Overnight sleep study performed at a lab? Y / N
Name of Sleep Lab _______________ Date _________
Home Sleep Study? Y / N
Provided by _____________________ Date _________
Physician who ordered test _______________________

Diagnosis: ☐ Mild ☐ Moderate ☐ Severe
The evaluation showed a
RDI of _______ -or- an AHI of ______
☐ I have never had a sleep study

CONSERVATIVE THERAPY ATTEMPTS: *(Even if you have not been diagnosed, how have you tried to help yourself?)*

☐ Avoidance of sleeping on back
☐ Weight loss program
Which one? __________________
☐ Smoking cessation
☐ Over the counter medications

☐ Nasal/snore strips
☐ Nasal sprays
☐ Oral surgery
☐ Prescription sleep aids
☐ UP3 surgery

☐ Pillar implants
☐ Tonsillectomy
☐ Positive airway pressure machine (CPAP)
☐ Other ____________________

____
Patient Signature and Date

PAP INTOLERANCE: *(Complete if you have tried any PAP therapy and have had difficulties. Mark as many as apply.)*

☐ Mask leaks
☐ Inability to get proper fit
☐ How many different masks have you tried? _____
☐ Discomfort from headgear
☐ Interrupted sleep
☐ Noisy/ Interrupts sleep of bed partner

☐ Restricted movements
☐ Does not seem to be effective
☐ Latex allergy
☐ Claustrophobia
☐ Unconscious need to remove while sleeping
☐ Other reasons ___________________________

Affidavit for Intolerance or Non-Compliance to CPAP, BiPAP or APAP

I have attempted to use PAP therapy to manage my sleep related breathing disorder and find it intolerable for the above reasons. Because of my intolerance/ inability to use PAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Repositioning Device.

____
Patient Signature and Date

Koala™ CenterForSleepDisorders

EPWORTH SLEEPINESS SCALE

PATIENT NAME____________________________AGE ___________ DOB _________________ TODAYS DATE _______________

Using the scale provided, please answer how likely you are to doze off or fall asleep in the following situations, if you allowed yourself to do so:

0 = Would never doze 1 = Slight Chance of Dozing 2 = Moderate Chance of Dozing 3 = High Chance of Dozing

ACTIVITY	SCORE
SITTING AND READING	______
WATCHING TV	______
SITTING, INACTIVE IN A PUBLIC PLACE (THEATER, MEETING, ETC)	______
AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK	______
LYING DOWN TO REST IN THE AFTERNOON WHEN 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	______

Please mark if you suffer from or have been told you have any of the following:

___________ Loud Snoring	___________ Frequent Nightime Urination	___________ Daytime Tiredness
___________ Diabetes	___________ Told you stop breathing during sleep	___________ COPD
___________ Depression	___________ Obesity/ Weight Gain	___________ Thyroid Dysfunction
___________ Acid Reflux	___________ Inability to Lose Weight	___________ Never Feel Rested
___________ CPAP Intolerance	___________ Wake up Gasping	___________ High Blood Pressure
___________ Lack of Energy	___________ Morning Headaches	___________ Decreased Concentration

For Women Only:

	___________ Pregnant	___________ Postmenopausal
___________ Premenopausal	___________ Polycystic Ovary Syndrome	___________ Hysterectomy

SIGNS & SYMPTOMS OF ORAL/FACIAL PAIN (Please circle all symptoms that apply)

Check Below:

- ☐ HEADACHES
- ☐ JAW JOINT PAIN
- ☐ JAW JOINT NOISE OR CLICKING
- ☐ LIMITED MOUTH OPENING
- ☐ EAR CONGESTION
- ☐ DIZZINESS
- ☐ RINGING IN EARS
- ☐ DIFFICULTY SWALLOWING
- ☐ LOOSE TEETH
- ☐ CLENCHING OR GRINDING
- ☐ FACIAL PAIN
- ☐ SENSITIVE TEETH
- ☐ CHEWING DIFFICULTIES
- ☐ NECK PAIN
- ☐ POSTURAL PROBLEMS
- ☐ TINGLING IN FINGERTIPS
- ☐ HOT & COLD TEETH SENSITIVITY
- ☐ NERVOUSNESS OR INSOMNIA