The Metz Center For Sleep

James E. Metz, DDS
1271 East Broad Street
Columbus, Ohio 43205
614-252-4444 (ph)
614-252-6474 (fax)
www.TheMetzCenter.com

SLEEP CONSULTATION & MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

CHIEF COMPLAINTS IN WHICH YOU ARE SEEKING TREATMENT

☐ Y ☐ N	DIFFICULTY SWALLOWING	☐ Y ☐ N	RINGING IN EARS
☐ Y ☐ N	DIZZINESS	☐ Y ☐ N	CPAP INTOLERANCE
☐ Y ☐ N	HEADACHES	☐ Y ☐ N	DIFFICULTY FALLING ASLEEP
☐ Y ☐ N	JAW CLICKING/POPPING	☐ Y ☐ N	DIFFICULTY MAINTAINING SLEEP
☐ Y ☐ N	JAW LOCKING	☐ Y ☐ N	FATIGUE
☐ Y ☐ N	JAW PAIN	☐ Y ☐ N	FREQUENT HEAVY SNORING
☐ Y ☐ N	LIMITED MOUTH OPENING	☐ Y ☐ N	GASPING UPON WAKENING
☐ Y ☐ N	NECK PAIN	☐ Y ☐ N	NIGHTTIME CHOKING SPELLS
☐ Y ☐ N	MORNING HEADACHES	☐ Y ☐ N	DAYTIME DROWSINESS
☐ Y ☐ N	PAIN UPON CHEWING	☐ Y ☐ N	SLEEPY WHILE DRIVING
☐ Y ☐ N	NOCTURNAL TEETH GRINDING/CLENCHING	☐ Y ☐ N	WITNESSED APNEIC EVENTS
☐ Y ☐ N	WAKING UNREFRESHED IN AM	☐	OTHER

Surgeries (Please Print Clearly)		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

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SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	Are you interested in a diet program?				☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				

FAMILY HEALTH HISTORY

☐ Y ☐ N	Asthma/COPD	☐ Y ☐ N	Thyroid trouble
☐ Y ☐ N	Sleep Disorder	☐ Y ☐ N	Mother snores
☐ Y ☐ N	Cancer	☐ Y ☐ N	Father snores
☐ Y ☐ N	Heart disease	☐ Y ☐ N	Mother has sleep apnea
☐ Y ☐ N	Diabetes	☐ Y ☐ N	Father has sleep apnea
☐ Y ☐ N	High blood pressure	☐ Y ☐ N	Obesity
☐ Y ☐ N	Stroke	☐ Other	

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HEALTH HISTORY

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ ALLERGIES	☐ CHEMOTHERAPY	☐ NERVOUSNESS
☐ ACID REFLUX	☐ CHRONIC FATIGUE	☐ FIBROMYALGIA
☐ TONSILS/ADENOIDS REMOVED	☐ CHRONIC PAIN	☐ DEPRESSION
☐ ANEMIA	☐ KIDNEY PROBLEMS	☐ DIABIETES
☐ ARTHRITIS	☐ LIVER DISEASE	☐ DIFFICULTY CONCENTRATING
☐ ASTHMA/COPD	☐ LUNG DISEASE	☐ EPILEPSY
☐ AUTO IMMUNE DISORDER	☐ MENOPAUSAL PROBLEMS	☐ FREQUENT URINATION
☐ HIGH BLOOD PRESSURE	☐ MULTIPLE SCLEROSIS	☐ GALL BLADDER PROBLEMS
☐ HEARTBURN	☐ MUSCULAR DYSTROPHY	☐ HEART DISEASE
☐ CANCER	☐ HEART MURMUR	☐ PACEMAKER
☐ HEART PALPITATIONS	☐ HEART VALVE REPLACEMENT	☐ HEPATITIS (A,B,C)
☐ HORMONE PROBLEMS	☐ INFECTIOUS MONONUCLEOSIS	☐ INSOMNIA
☐ INTESTINAL DISORDERS	☐ POOR DIGESTION	☐ POLIO
☐ PARKINSONS DISEASE	☐ PNEUMONIA	☐ POOR CIRCULATION
☐ PSYCHIATRIC CARE	☐ RADIATION TREATMENT	☐ REDUCED SEX DRIVE
☐ RHEUMATIC FEVER	☐ SCARLET FEVER	☐ SCOLIOSIS
☐ SHORTNESS OF BREATH	☐ SINUS PROBLEMS	☐ SKIN DISORDER
☐ SLEEP APNEA	☐ STROKE	☐ TUBERCULOSIS
☐ TUMORS	☐ MEMORY LOSS	☐ EMOTIONAL UPSETS

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THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (i.e. a theater or a meeting)	_____
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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Signature:_____ Date: __/__/20__

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Name:_____
Height:_____ Weight:_____
Age:_____ Male/Female:_____

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone ever **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

Signature:_____ Date:_____

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Affidavit of Intolerance or Non-Compliance or Refusal to CPAP

(Continuous Positive Air Pressure)

I have attempted to use or refuse to use the nasal CPAP device to manage my sleep disordered breathing (obstructive sleep apnea) and find it intolerable to use on a regular basis due to the following reason(s):

☐ PAP is not effective in controlling my symptoms.

☐ I am unable to sleep with the CPAP equipment in place.

☐ Noise from the device disturbs my sleep or my bed partner's sleep.

☐ I cannot find a comfortable mask.

☐ The mask leaks.

☐ I develop sinus / throat / ear / lung infections.

☐ I am allergic to materials in the mask and head straps.

☐ Claustrophobia.

☐ I unconsciously remove the CPAP apparatus at night.

☐ Pressure from the mask and straps causes tissue breakdown.

☐ My job and/or lifestyle prevents this form of therapy (e.g. Active Army / National Guard duty).

☐ Prior throat surgery makes CPAP intolerable.

☐ Other_____

Because of my inability to tolerate CPAP and my need to control the signs and symptoms of sleep disordered breathing (OSA), I wish to use an alternative method of treatment. This form of therapy is oral appliance therapy (OAT).

Signed:_____Date:_____