HST America

PRE-APPOINTMENT QUESTIONNAIRE

Fax to: (888) 461-5751
Email to: referrals@hstamerica.com

1. PATIENT INFORMATION

Full name: _____ Date of birth: _____ Gender: _____

Address: _____ Best contact #: _____

City: _____ State: _____ Zip: _____ Alternative contact #: _____

Email: _____ Weight (lbs): _____ Height (in): _____

2. SLEEP APNEA RISK ASSESSMENT

a. Check "Yes" or "No" in response to each question.
b. If filling on paper, add up the points for each "Yes" answer and write in the "TOTAL" box.
If completing in PDF form this section will fill automatically.
c. Select the corresponding Risk Level

Have you ever been told you stop breathing while asleep?	☐ Yes ☐ No	8
Have you ever fallen asleep or nodded off while driving?	☐ Yes ☐ No	6
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	☐ Yes ☐ No	6
Do you feel excessively sleepy during the day?	☐ Yes ☐ No	4
Do you snore or have you ever been told that you snore?	☐ Yes ☐ No	4
Have you had weight gain and found it difficult to lose?	☐ Yes ☐ No	2
Have you taken medication for, or been diagnosed with high blood pressure?	☐ Yes ☐ No	2
Do you kick or jerk your legs while sleeping?	☐ Yes ☐ No	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	☐ Yes ☐ No	3
Do you wake up with headaches during the night or in the morning?	☐ Yes ☐ No	3
Do you have trouble falling asleep?	☐ Yes ☐ No	4
Do you have trouble staying asleep once you fall asleep?	☐ Yes ☐ No	4
Check the risk level below that pertains to the score box on the right.	**TOTAL:**	0

RISK LEVEL:	☐ **LOW (0-7)**	☐ **MODERATE (8-11)**	☐ **HIGH (12-15)**	☐ **SEVERE (16+)**

3. SIGNS & SYMPTOMS

☐ Hypertension ☐ Snoring
☐ Depression ☐ Diabetes
☐ Stroke/heart disease ☐ Acid reflux
☐ Teeth grinding ☐ Unrefreshed sleep

☐ Family history of snoring or sleep apnea
☐ Neck circumference (in): _____

PATIENT: please present completed questionnaire, ID and medical insurance card to front desk.

4. SLEEP HISTORY

Have you ever been diagnosed with a sleep disorder?	☐ Yes ☐ No
Have you <u>ever</u> used a CPAP machine?	☐ Yes ☐ No
Are you <u>currently</u> using a CPAP machine?	☐ Yes ☐ No
If yes, do you use your CPAP less than 5 times per week?	☐ Yes ☐ No
Have you tried CPAP, and would you prefer an oral appliance?	☐ Yes ☐ No

PHYSICIAN: please sign to confirm you have reviewed this form with the patient.

_____ _____
Signature *Date*