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Patient Name _____ Gender _____ DOB _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Email _____

Medical Insurance Company _____ How did you hear about our office? _____

Referring Physician's Name _____ Physician's Phone _____ Physician's Location (City) _____

Patient Sleepiness Scale (Risk Factors): Please check all that apply

	Pt	Additional comments below
1. I have been told I stop breathing while asleep	<input type="checkbox"/> 4	
2. I have fallen asleep or nodded off while driving	<input type="checkbox"/> 3	
3. I've woken up with shortness of breath/gasping or my heart racing	<input type="checkbox"/> 3	
4. I feel excessively sleepy or fatigued during the day/ upon waking	<input type="checkbox"/> 2	
5. I snore or have been told that I snore	<input type="checkbox"/> 2	
6. I have had weight gain and found it difficult to lose	<input type="checkbox"/> 2	
7. I have been diagnosed with high blood pressure (Hypertension)	<input type="checkbox"/> 2	
8. It takes me less than 10 minutes to fall asleep	<input type="checkbox"/> 2	
9. I wake up more than 1 time per night	<input type="checkbox"/> 2	
10. I wake up with headaches	<input type="checkbox"/> 2	

Total points from above: _____ Risk Level Score: **Low: 0-4** **Moderate: 4-6** **High: 6-8** **Severe: 8+**

Patient Health History (Signs & Symptoms): Please check all that apply

- | | |
|--|--|
| <input type="checkbox"/> Brain Fog | <input type="checkbox"/> Family History of Sleep Apnea |
| <input type="checkbox"/> Depression / Anxiety | <input type="checkbox"/> Family History of Stroke |
| <input type="checkbox"/> Smoker / Drinker | <input type="checkbox"/> Family History of Heart Disease |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Acid Reflux / GERD |
| <input type="checkbox"/> Irritability / Moodiness | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Wake Up with Dry Mouth | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sinus / Allergy Issues | <input type="checkbox"/> Deviated Septum |
| <input type="checkbox"/> Previous Diagnosis of OSA | <input type="checkbox"/> Grind Teeth / Bruxism |

Office staff will complete the form below

<input type="checkbox"/> BMI > 30	<input type="checkbox"/> Occlusion
<input type="checkbox"/> Narrow upper arch	_____
<input type="checkbox"/> Visual airway obstruction	
<input type="checkbox"/> Large/scalloped tongue	
<input type="checkbox"/> Neck size: Male ≥ 16.5" or Female ≥ 16"	
_____ " _____ lbs	_____
Height	Weight
_____ inches	_____
Neck Size	Blood Pressure
	Heart Rate

Patient Signature: _____ **Date:** _____

I authorize this practice to have and release my medical information for the purpose of the coordination of care

Notes:

Married / Single Sleeps Alone Y / N Children Y / N

The Sleep Apnea Center of Novi

Dr. James C. Ross
 23975 Novi Rd., Suite A104
 Novi, MI 48375
 NPI#:1225465289
 State Lic#:13573
 Office Contacts: Zac, Emily
 Phone: 248-513-4367
 Fax: 248-347-3647
 info@sleepbetter.expert

Patient chart notes reviewed and approved by: _____ **Date:** _____