PHYSICIANS' CLINIC
of Iowa, P.C.

ENT, Head and Neck Surgery

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Health History Form for Sleep Surgery Consultation

****PLEASE BRING THIS COMPLETED FORM, PHOTO ID, INSURANCE CARD(S) AND LIST OF CURRENT MEDICATIONS TO YOUR APPOINTMENT.**

Appointment Date and Time: ________________________

Name: _______________________________ Today's Date:__________________________

Date of Birth: _______________

What is your current height and weight? ____ ft ____ in ________ lbs

Have you completed a **diagnostic** sleep study in the last 2 years? (Does not include titration studies, oximetry reports or CPAP/BiPAP compliance reports): YES NO

If yes, please list:

- Date of study: ___________________
- Type of study (please circle): Home study Lab study
- Facility: __________________________________

Have you tried CPAP or BiPAP in the past? YES NO

- If yes, how many months/years did you use it? _________________________
- Approximately how long has it been since you last used it? _____________________

Have you already returned your CPAP? YES NO

Are you currently using your CPAP at least 4 hours/night for at least 5 days/week? YES NO

Have you used an oral appliance/mouthguard for sleep apnea? YES NO

Which mask styles have you trialed? (circle all that apply)

Full face mask Nasal mask Nasal pillow

Turn Page Over

Describe the struggles you have with CPAP/BiPAP: ____
____
____
____

Do you typically sleep less than 6 hours/night? YES NO

Do you have trouble **falling asleep** 3 or more times/week? YES NO

Do you have trouble **staying asleep** 3 more times/week? YES NO

Are you currently being treated for **insomnia**? YES NO

Do you frequently have an urge to move your legs or experience a crawling sensation in your legs close to bedtime? YES NO

If you are currently being treated for **Restless Leg Syndrome (RLS)**, are your symptoms poorly controlled?

YES NO

Have you had **prior airway-related surgeries**? (Septoplasty, tonsillectomy, UP3, etc): YES NO

- If yes, please list: ____

Have you had **prior surgeries of the neck or chest** (including breast augmentation)? YES NO

- If yes, please list: ____

Do you struggle with chronic **sinus infections** or **nasal obstruction**? YES NO

Do you have a personal history of **cancer?** YES NO

- If yes, please list the type(s) of cancer: ____
- Did you undergo surgery, chemotherapy or radiation? YES NO
- If yes, please list: ____

Do you see a cardiologist for treatment or management of any **heart conditions**? YES NO

If yes, please list:

- Heart condition(s): ____
- Name of cardiologist: ____
- Facility/Location: ____

Do you take any **blood thinners or aspirin?** YES NO

- If yes, please list the medication and dosage: ______________________________________

Do you have any existing **implanted devices?** (pacemaker/defibrillator, stents, nerve stimulator, etc):

YES NO

- If yes, please list: ____

Do you take any **diuretics** (also called “water pills”)? YES NO

- If yes, please list the medication and dosage: ____

Are you **diabetic?** YES NO

- If yes, please list the names and dosages of your diabetes medications/insulin:

____

Do you have a personal history of **MRSA** (Methicillin-resistant staphylococcus aureus) or **VRE** (Vancomycin-resistant Enterococcus) infection? YES NO

- If yes, have you received a negative lab result since the infection occurred?

  YES NO

Do you have a family history of **malignant hyperthermia?** YES NO

Do you have a family history of any **bleeding disorders?** YES NO

- If yes, please list the name of the condition(s) and the family member(s) afflicted: ____

Have you been diagnosed with **rheumatoid arthritis**? YES NO

Do you routinely carry heavy equipment for a job or hobby? YES NO

- If yes, please explain: ____