ISLAND CPAP
SERVICES AND SUPPLIES

Patient Name: _____

Bed Partner: Y / N

What brings you here today? _____

Have you ever been tested for Sleep Apnea? □ Yes □ No If yes, when? _____

Results: _____

Symptoms:

- ☐ Snoring
- ☐ Pauses in breathing at night
- ☐ Choking / Gasping / Short of Breath
- ☐ Bruxism /Teeth grinding/Clenching
- ☐ Frequent awakenings
- ☐ Limb jerking /twitching
- ☐ Restless sleep – tossing and turning
- ☐ Naps - #_____/ week
- ☐ Insomnia _____
- ☐ Family History of Obstructive Sleep Apnea
- ☐ Refreshed upon awakening? Y / N / Sometimes
- ☐ Nocturia (> 2 /night) Up to void: _____
- ☐ Daytime Fatigue/tiredness _____
- ☐ Morning Headaches
- ☐ Migraines
- ☐ Depression - on medications? Y / N
- ☐ Memory loss
- ☐ Poor concentration
- ☐ Irritable / Moody
- ☐ Anxiety
- ☐ Night sweats
- ☐ Claustrophobia
- ☐ **Hypertension** - On meds? Yes / No
  -Controlled? Yes / No
  -Current BP: _____
- ☐ **Gastric Reflux** – on meds? Yes / No

Other Health Conditions:

- ☐ Smoker _____yrs _____ppd
- ☐ Ex-smoker ☐ Quit_____
- ☐ Lung Disease _____
- ☐ Heart Disease _____
- ☐ **Diabetes** _____
- ☐ Sinus Problems/nasal allergies _____
  _____
- ☐ Fractured nose ☐ Deviated Septum
- ☐ Other _____

• Medications: _____

_____

Typical Sleep Position: Back / Sides / Stomach

Usual bedtime: _____ waking time: _____ # of hrs of sleep/night _____

Occupation: _____ Do you work shift work /nights?: Yes No

Caffeine /day = _____ Alcohol? Y / N _____ Rec. Drugs Use? Y / N _____

Height: _____/_____ **Weight: _____** **BMI:_____**
(feet / inches) (lbs**)**