Raphaelson Dental Sleep Center
450 Grand Blvd.
Deer Park, NY 11729
Phone: 631-667-4080
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Sleep Breathing Disorder Intake Form

Patient's Full Name:________________________________ Date of Birth:_____________Age:________

Patients Home Address:____

Patients Home Phone:_________________________ Cell Phone: ________________________________

Medical Insurance:_________________ Phone Number:______________________________________

ID:__________________ Group:____________ Subscriber:___________________________________

Claims Address:____

Have you completed a Sleep Test before: YES NO If YES, how long ago:__________

Sleep Lab:____
(Name, Address, and Number)

Physician that referred you for Sleep Study: ____
(Name, Address, and Number)

Primary Care Physician: ____
(Name, Address, and Number)

Referred By:____

Medications: ____

____

PLEASE ANSWER ALL THE QUESTIONS BELOW

Have you ever been told you snore? (Yes) (No)
Has anyone ever witnessed that you stop breathing while sleeping and or snoring? (Yes) (No)
Have you ever been diagnosed with Sleep Apnea? (Yes) (No)
Are you having difficulty loosing weight? (Yes) (No)
Do you take sedatives? (Yes) (No)
Do you Smoke? (Yes) (No) ________per week
Do you drink Alcohol? (Yes) (No) ________per week

Check any conditions that apply to you:

__ Class III or IV congestive heart failure
__ Stage III or IV cardiac-obstructive pulmonary disease/lung disease
__ Significant and persistent cardiac arrhythmia
__ Pulmonary hypertension
__ Neurodegenerative disorder or cognitive impairment
__ Restless Leg Syndrome
__ Thyroid Disorder
__ **Heart Disease**

__ Neuromuscular weakness
__ **History of stroke** Date:
__ Suspected narcolepsy
__ **High Blood Pressure**
__ History of myocardial infarction Date:
__ **Diabetes**
__ COPD
__ Depression/Mood Disorders
__ GERD