



SIERRA

SLEEP

AIRWAY AND WELLNESS CENTER

Breathe well... Sleep Well... Live Well...

Patient Name: _____

Date of Birth: _____

Referral Date: _____

Phone: _____

Email: _____

Preferred Contact Method: Text / Call / Email

Referring Provider: _____

Comprehensive sleep/airway evaluation

Please mark all that apply:

Oral Health Concerns:

- Tongue Tie/Frenum restrictions
- Growth/Development
- Bruxism/Clenching
- TMJ/TMD
- Erosion/Abrasions
- Difficulty Swallowing
- Tonsils/Malampatti

Medical HX/Family HX Concerns:

- ADD/ADHD
- Dementia/Alzheimer's
- Disease Depression/anxiety
- High Blood Pressure
- Diabetes
- Cpap Machine
- Sleep Apnea

Sleep Concerns:

- Insomnia
- Snoring/Gasping for Air
- Mouth breathing
- Restless Leg Syndrome
- Sleep Talking/Walking
- Bed Wetting

Breathing/Daily Concerns:

- Allergies
- Asthma
- Mouth Breathing
- Fatigue
- Headaches
- Ear Concerns
- Memory loss/Brain Fog