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/Abfractions
- ☐ 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

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