Patient Intake Form

Affidavit for Intolerance to Positive Airway Pressure (PAP) Device

---

I HAVE ATTEMPTED to use Positive Air Pressure CPAP, APAP, etc to manage my Obstructive Sleep Apnea & find it intolerable to use on a regular basis for the following reason(s): **(Check all that apply)**

- ☐ Mask leaks
- ☐ An inability to get mask to fit properly
- ☐ Discomfort caused by the straps and headgear
- ☐ Disturbed or interruped sleep caused by the presence of device
- ☐ Noise from the device disturbing sleep or bed partner's sleep
- ☐ CPAP restricts movements during sleep
- ☐ CPAP does not seem to be effective
- ☐ Pressure on upper lip causes tooth-related problems
- ☐ Latex allergy
- ☐ Claustrophobic associations
- ☐ An unconscious need to remove the CPAP apparatus at night
- ☐ CPAP use caused GI / stomach / intestinal problems
- ☐ CPAP irritated my nasal passages or sinuses
- ☐ CPAP irritated the skin on my nose and face
- ☐ Causes a dry nose or dry mouth
- ☐ Causes eye irritation due to air leaks
- ☐ Other : _____

I HAVE NOT ATTEMPTED to use Positive Air Pressure CPAP, APAP, etc. (Continues Positive Air Pressure) device and would prefer to use an oral applience for the following reason(s): **(Check all that apply)**

- ☐ I'm worried that mask, straps/headgear will cause discomfort
- ☐ I'm worried that noise from the device will disturb me and/or my bed partner's sleep I'm
- ☐ Worried that the device will restrict movement during sleep
- ☐ I have latex allergy
- ☐ I suffer from claustrophobia
- ☐ I travel frequently and worried that a CPAP device will be cumbersome to transport
- ☐ Other : _____

Because of my inability to use a CPAP device, I wish to have an alternative method of treatment. I would like to try an oral appliance to control my snoring and obstructive sleep apnea.

_____ _____

Signature of Patient or Legal Guardian | Date