Sleep Dental Services
Feeling Better and Living Longer through Healthy Sleep

DENTAL MEDICAL HISTORY

Patient Name: _____/_____/_____
Age: _____ Date of Birth: _____/_____/_____ ▭ Male ▭Female
Mailing Address: _____
City _____ State _____ Zip Code _____
Physical Address (if different): _____
City _____ State _____ Zip Code _____
Phone #: _____ Work Phone # _____
Cell #: _____ Email _____
SS#: _____
Spouse Information: Name: _____ DOB: _____

How were you referred to our office? ▭Physician ▭Sleep Specialist ▭Dentist ▭Friend
▭Website ▭Radio▭TV ▭Newspaper ▭Other _____

Insurance Information: Primary
Insured: Self Spouse Father Mother Other: _____
Name: _____Date of Birth: _____/_____/_____
Address (if different): _____
Employer: _____SS#: _____
Insurance Company: _____
ID#: _____ Group #: _____
Insurance Company Address: _____
City _____ State _____ Zip Code _____

Insurance Information: Secondary

Insured: ▭Self ▭Spouse ▭Father ▭Mother ▭Other: _____
Name: _____Date of Birth: _____/_____/_____
Address (if different): _____
Employer: _____SS#: _____

Insurance Company: _____
ID#: _____ Group #: _____
Insurance Company Address: _____
City _____ State _____ Zip Code _____

Physicians:

Name of Primary Care Physician: _____
Phone: _____ Address: _____
City _____ State _____ Zip Code _____

Dentist: _____
Phone: _____ Address: _____
City _____State _____Zip Code _____

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I. CHIEF COMPLAINTS:

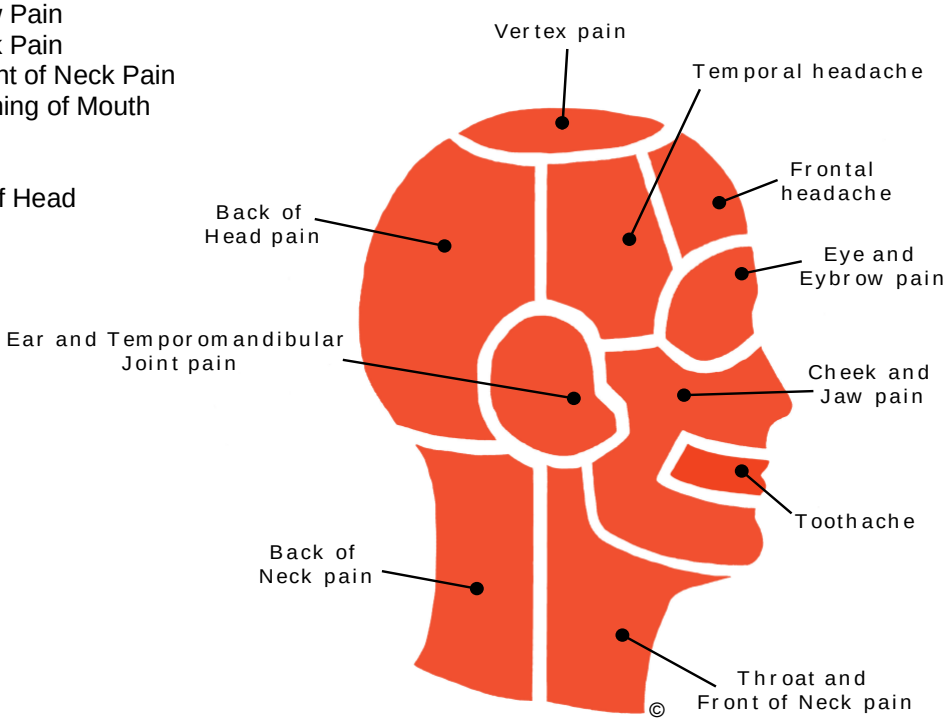
Please check the following chief complaints:

- ▭ Obstructive SleepApnea
- ▭ Snoring
- ▭ Fatigue
- ▭ Daytime Drowsiness
- ▭ Gasping for breath
- ▭ Insomnia
- ▭ Witnessed arousals
- ▭ Hypersomnia
- ▭ CPAP Intolerance
- ▭ Nasal Congestion
- ▭ Restless Leg Syndrome
- ▭ Doctor Recommended

Other: _____

Please refer to the diagram below and indicate areas of pain or discomfort you are experiencing.

- ▭ Back of Head Pain
- ▭ Temporal Headache
- ▭ Frontal Headache
- ▭ Ear & TMJ pain
- ▭ Eye & Eyebrow Pain
- ▭ Cheek & Jaw Pain
- ▭ Back of Neck Pain
- ▭ Throat & Front of Neck Pain
- ▭ Limited Opening of Mouth
- ▭ Jaw Locking
- ▭ Toothache
- ▭ Vertex/Top of Head
- ▭ None



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DENTAL MEDICAL HISTORY

II. SLEEP HISTORY:

Please answer the following questions regarding your sleep history.

Do you use an alarm to wake up? ☐Yes ☐No
Do you take naps? ☐Yes ☐No
Hours of Sleep Daily:
☐< 6 hours
☐< 6-8 hours
☐> 8 hours

Average Bedtime: _____
Average Wake Time: _____

Sleep Position:
☐Back
☐Stomach
☐Side

Upon waking in the morning, do you feel?

Groggy	☐Yes	☐No
Tired	☐Yes	☐No
Headache	☐Yes	☐No
Refreshed	☐Yes	☐No

Insomnia:

Trouble Falling Asleep:	☐Yes	☐No
Trouble Returning to Sleep:	☐Yes	☐No
Shift work:	☐Yes	☐No

Quality and Activity:

Light sleeper	☐Yes	☐No
Restless	☐Yes	☐No
Uncomfortable leg sensation	☐Yes	☐No
Kicking	☐Yes	☐No
Teeth grinding	☐Yes	☐No

Sleep Behavior:

Walking	☐Yes	☐No
Talking	☐Yes	☐ No
Violence	☐Yes	☐No

Childhood History:

Snored	☐Yes	☐No
Sleep Walked	☐Yes	☐No
Bedwetting	☐Yes	☐No
Scary Dreams	☐Yes	☐No

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CPAP INTOLERANCE: (Continuous Positive Airway Pressure Device)

Have you tried an oral appliance or CPAP in the last 5 years? ☐yes ☐no

If you have attempted treatment with a CPAP device, but were not able to tolerate it please tell us why:

☐ Mask leaks
☐ I was unable to get the mask to fit properly
☐ Discomfort caused by the straps and headgear
☐ Disturbed or interrupted sleep caused by the presence of the device
☐ Noise from the device disturbing my sleep and/or bed partner's sleep
☐ CPAP restricted movements during sleep
☐ CPAP does not seem to be effective
☐ Pressure on the upper lip, causing tooth related problems
☐ A latex allergy
☐ Claustrophobic associations
☐ An unconscious need to remove the CPAP apparatus at night
☐ Other: _____

- ☐ I have not attempted to use a CPAP device and would prefer to use an oral appliance for the following reason(s):
- ☐ I'm worried that the mask, straps/headgear will cause discomfort
- ☐ I'm worried that the 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 a latex allergy
- ☐ I suffer from claustrophobia
- ☐ I travel frequently and am 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 in an attempt to control my snoring and obstructive sleep apnea.

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they have affected you. Use the following scale to check the most appropriate number for each situation.

0=never doze 1=slight chance of dozing 2=moderate chance of dozing 3=high chance of dozing

SCALE	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting, inactive, in a public place (theater, meeting, etc.)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Score _____

X_____ _____
Patient Signature **Date**

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DENTAL MEDICAL HISTORY

III. REVIEW OF SYSTEMS:

Do you have any of the following problems or conditions?

CONSTITUTIONAL			
Underweight	___YES	___NO	___DENIES
Overweight	___YES	___NO	___DENIES
Weight loss	___YES	___NO	___DENIES
Fatigue	___YES	___NO	___DENIES
Fevers	___YES	___NO	___DENIES
Chronic fatigue syndrome	___YES	___NO	___DENIES
EAR, NOSE, THROAT & MOUTH			
Dry mouth	___YES	___NO	___DENIES
Mouth breathing	___YES	___NO	___DENIES
Tongue thrust	___YES	___NO	___DENIES
Large tonsils	___YES	___NO	___DENIES
Ear aches/infections	___YES	___NO	___DENIES
Hearing loss	___YES	___NO	___DENIES
Tinnitus (ringing of ears)	___YES	___NO	___DENIES
Postnasal drainage	___YES	___NO	___DENIES
Headaches	___YES	___NO	___DENIES
Swallowing Disorder	___YES	___NO	___DENIES
EYES			
Poor vision	___YES	___NO	___DENIES
Dry eyes	___YES	___NO	___DENIES
Eye pain	___YES	___NO	___DENIES
ALLERGIC/IMMUNOLOGIC			
Allergies	___YES	___NO	___DENIES
Asthma	___YES	___NO	___DENIES
Sinus problems	___YES	___NO	___DENIES
Lupus	___YES	___NO	___DENIES
HIV/Aids	___YES	___NO	___DENIES
RESPIRATORY			
Lung disease	___YES	___NO	___DENIES
Shortness of breath	___YES	___NO	___DENIES
Coughing	___YES	___NO	___DENIES
Wheezing	___YES	___NO	___DENIES
Snoring	___YES	___NO	___DENIES
CARDIOVASCULAR			
Heart disease	___YES	___NO	___DENIES
CVA/Stroke	___YES	___NO	___DENIES
Pace maker	___YES	___NO	___DENIES
Heart palpitations	___YES	___NO	___DENIES
Chest pain	___YES	___NO	___DENIES
Vascular disease	___YES	___NO	___DENIES
Hypertension	___YES	___NO	___DENIES
Swollen hands & feet	___YES	___NO	___DENIES

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GASTROINTESTINAL			
Gastric reflux	___YES	___NO	___DENIES
Diarrhea	___YES	___NO	___DENIES
Constipation	___YES	___NO	___DENIES
Stomach ulcers	___YES	___NO	___DENIES
Gall bladder problems	___YES	___NO	___DENIES
GENITO/URINARY			
Kidney disease	___YES	___NO	___DENIES
Prostate problems	___YES	___NO	___DENIES
Painful, frequent urination	___YES	___NO	___DENIES
Impotence	___YES	___NO	___DENIES
Menstrual cramping	___YES	___NO	___DENIES
Pregnancy	___YES	___NO	___DENIES
Birth control	___YES	___NO	___DENIES
Menopausal problems	___YES	___NO	___DENIES
Hepatitis	___YES	___NO	___DENIES
INTEGUMENTARY (SKIN)			
Dry skin	___YES	___NO	___DENIES
Rashes	___YES	___NO	___DENIES
Brittle nails	___YES	___NO	___DENIES
Hair loss	___YES	___NO	___DENIES
Wounds that won't heal	___YES	___NO	___DENIES
MUSCULOSKELATAL			
Back aches	___YES	___NO	___DENIES
Scoliosis	___YES	___NO	___DENIES
Fibromyalgia	___YES	___NO	___DENIES
Neck ache	___YES	___NO	___DENIES
Limited range of motion of neck	___YES	___NO	___DENIES
Joint pain	___YES	___NO	___DENIES
Loss of strength	___YES	___NO	___DENIES
Osteoarthritis	___YES	___NO	___DENIES
Muscular dystrophy	___YES	___NO	___DENIES
NEUROLOGICAL			
Numb fingers & hands	___YES	___NO	___DENIES
Paralysis	___YES	___NO	___DENIES
Dizziness	___YES	___NO	___DENIES
Memory loss	___YES	___NO	___DENIES
Fainting spells	___YES	___NO	___DENIES
Seizures/epilepsy	___YES	___NO	___DENIES
Shaking/twitching	___YES	___NO	___DENIES
Hand tremors	___YES	___NO	___DENIES
Parkinson's disease	___YES	___NO	___DENIES
Muscular Sclerosis	___YES	___NO	___DENIES
PSYCHIATRIC			
Emotional upsets	___YES	___NO	___DENIES
Anxiety	___YES	___NO	___DENIES
Depression	___YES	___NO	___DENIES
Psychiatric disorder	___YES	___NO	___DENIES
ADHD	___YES	___NO	___DENIES
Learning disability	___YES	___NO	___DENIES
Drug abuse	___YES	___NO	___DENIES

DENTAL MEDICAL HISTORY

Consultation?	___YES	___NO	___DENIES
HEMATOLOGIC/LYMPHATIC			
Anemia/blood disorders	___YES	___NO	___DENIES
Abnormal bleeding	___YES	___NO	___DENIES
Cancer	___YES	___NO	___DENIES
Chemo/radiation	___YES	___NO	___DENIES
Nose bleeds	___YES	___NO	___DENIES
ENDOCRINE			
Rheumatoid arthritis	___YES	___NO	___DENIES
Cold Hands & feet	___YES	___NO	___DENIES
Hypothyroidism	___YES	___NO	___DENIES
Diabetes	___YES	___NO	___DENIES
Hypoglycemia	___YES	___NO	___DENIES
Scleroderma	___YES	___NO	___DENIES
OTHER	___YES	___NO	___DENIES

NOTES: PLEASE ELABORATE FURTHER ON ANY DISEASE OR DISORDER:

_____
_____
_____
_____
_____
_____
_____

IV. Medications:

Medication	Dose	Rx	Reason

Allergies to Medications:

Antibiotics	___YES	___NO	Latex	___YES	___NO
Barbituarates	___YES	___NO	Sedatives	___YES	___NO
Codeine	___YES	___NO	Sulfur Drugs	___YES	___NO
Iodine	___YES	___NO	Foods	___YES	___NO

Other: _____

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V. PAST, FAMILY AND SOCIAL HISTORY:

A. PAST HISTORY:

Injuries:

Have you sustained any injury due to an accident? ___Yes ___No

If yes;

Date of Accident	Injuries Sustained

Surgeries:

Previous Surgeries? ___ Yes ___No

Date of Surgery	Type of Surgery

B. FAMILY HISTORY:

Has any parent or sibling experienced any of the following conditions?

Heart disease	___YES	___NO	___DENIES
High Blood Pressure	___YES	___NO	___DENIES
Diabetes	___YES	___NO	___DENIES
Depression	___YES	___NO	___DENIES
Stroke	___YES	___NO	___DENIES
Sleep Apnea	___YES	___NO	___DENIES
Cancer	___YES	___NO	___DENIES

C. SOCIAL HISTORY:

1. Recent alcohol consumption:
   - ___Denies
   - ___< 1 per week
   - ___3 or fewer drinks per week
   - ___1-2 drinks per day
   - ___> 2 drinks per day

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DENTAL MEDICAL HISTORY

SOCIAL HISTORY, CONT'D

History of Alcoholism: ☐NOW ☐PAST ☐NEVER Years of use: _____ yr
Alcohol Consultation ☐

2. Tobacco Usage:
   - ☐Denies
   - ☐< 1 pack per week
   - ☐< 1 pack per day

   History of tobacco use ☐ Years of use: _____ yrs.

   Tobacco Consultation ☐

3. Caffeine intake:

Most common form of caffeine intake:

☐Coffee ☐Tea ☐Energy drinks ☐Soda ☐Caffine capsule

_____ Servings of caffeine in the morning
_____ Servings of caffeine in the afternoon
_____ Servings of caffeine in the evening

☐Other form of caffeine intake (i.e. coffee, energy drinks, soda, caffeine capsule) and time of day they are taken.

_____
_____
_____

Notes:

Anything else you would like to mention regarding your family or social history:

_____
_____
_____
_____

X_____
PATIENT SIGNATURE

_____
DATE

