Medical History Questionnaire

OFFICE USE
Patient ID:_____

NAME: ________________________________

FORM DATE: ____/____/_______

DATE OF BIRTH: ___/___/______

Allergens

- ☐ No known allergens
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Plastic
- ☐ Sedatives
- ☐ Sleeping pills
- ☐ Sulfa drugs

Other: ____________________ ____________________

Current Medications

Medicine	Dosage/Frequency	Reason
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Other

Medical History

Significant	Medical Condition	Current	Never	Past	Date / Note
☐	Acid reflux	☐	☐	☐	__________
☐	Anemia	☐	☐	☐	__________
☐	Atherosclerosis	☐	☐	☐	__________
☐	Arthritis	☐	☐	☐	__________
☐	Asthma	☐	☐	☐	__________
☐	Autoimmune disorder	☐	☐	☐	__________
☐	Bleeding easily	☐	☐	☐	__________
☐	Blood pressure - High	☐	☐	☐	__________
☐	Blood pressure - Low	☐	☐	☐	__________
☐	Bruising easily	☐	☐	☐	__________
☐	Cancer	☐	☐	☐	__________
☐	Chemotherapy	☐	☐	☐	__________
☐	Chronic fatigue	☐	☐	☐	__________
☐	Chronic pain	☐	☐	☐	__________
☐	COPD	☐	☐	☐	__________
☐	Coronary heart disease	☐	☐	☐	__________
☐	Current pregnancy	☐	☐	☐	__________
☐	Depression	☐	☐	☐	__________

Medical History

Significant	Medical Condition	Current	Never	Past	Date / Note
☐	Diabetes	☐	☐	☐	___________
☐	Difficulty sleeping	☐	☐	☐	___________
☐	Dizziness	☐	☐	☐	___________
☐	Emphysema	☐	☐	☐	___________
☐	Epilepsy	☐	☐	☐	___________
☐	Fibromyalgia	☐	☐	☐	___________
☐	Glaucoma	☐	☐	☐	___________
☐	Gout	☐	☐	☐	___________
☐	Heart attack	☐	☐	☐	___________
☐	Heart murmur	☐	☐	☐	___________
☐	Heart pacemaker	☐	☐	☐	___________
☐	Heart valve replacement	☐	☐	☐	___________
☐	Hemophilia	☐	☐	☐	___________
☐	Hepatitis	☐	☐	☐	___________
☐	Hypertension	☐	☐	☐	___________
☐	Hypoglycemia	☐	☐	☐	___________
☐	Immune system disorder	☐	☐	☐	___________
☐	Ischemic heart disease (reduced blood supply)	☐	☐	☐	___________
☐	Kidney problems	☐	☐	☐	___________
☐	Liver disease	☐	☐	☐	___________
☐	Meniere's disease	☐	☐	☐	___________
☐	Mitral valve prolapse	☐	☐	☐	___________

Significant	Medical Condition	Current	Never	Past	Date / Note
☐	Mood disorder	☐	☐	☐	___________
☐	Multiple sclerosis	☐	☐	☐	___________
☐	Muscular dystrophy	☐	☐	☐	___________
☐	Nasal allergies	☐	☐	☐	___________
☐	Neuralgia	☐	☐	☐	___________
☐	Osteoarthritis	☐	☐	☐	___________
☐	Osteoporosis	☐	☐	☐	___________
☐	Parkinson's disease	☐	☐	☐	___________
☐	Prior orthodontic treatment	☐	☐	☐	___________
☐	Psychiatric care	☐	☐	☐	___________
☐	Radiation treatment	☐	☐	☐	___________
☐	Rheumatic fever	☐	☐	☐	___________
☐	Rheumatoid arthritis	☐	☐	☐	___________
☐	Sinus problems	☐	☐	☐	___________
☐	Sleep apnea	☐	☐	☐	___________
☐	Stroke	☐	☐	☐	___________
☐	Tendency for ear infections	☐	☐	☐	___________
☐	Thyroid disorder	☐	☐	☐	___________
☐	Tuberculosis	☐	☐	☐	___________
☐	Tumors	☐	☐	☐	___________
☐	Urinary disorders	☐	☐	☐	___________

Other

	Medical Condition	Current	Past	Date / Note		Medical Condition	Current	Past	Date / Note
☐	______________________	☐	☐	___________	☐	______________________	☐	☐	___________

Family History

Has any member of your family (parent, sibling, or grandparent) had:

☐ Cancer ☐ Diabetes ☐ Stroke

☐ Heart disease ☐ High blood pressure ☐ Sleep disorder

☐ Obesity ☐ Father snores ☐ Father has sleep apnea

☐ Thyroid disorder ☐ Mother snores ☐ Mother has sleep apnea

Social History

Patient's Occupation ______________________ Employer ______________________

Tobacco Use: Cigarettes ☐ Never smoked	☐ Current smoker # of packs per day ____ # of years ____	☐ Quit When did you quit? ______________

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No If yes, # of drinks per week: ____

Caffeine Intake: ☐ None ☐ Coffee/Tea/Soda # of cups per day: ____

Additional:

☐ Regular exercise

Patient Signature

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature: Date:

______________________________ ______________

I certify that the medical history information is complete and accurate.

Patient Signature: Date:

______________________________ ______________

Review of Systems

OFFICE USE
Patient ID:_____

NAME: ____________________ __ ____________________

FORM DATE: ____/____/_______

DATE OF BIRTH: ___/___/______

General

☐ Within Normal Limits

☐ Reported ☐ Denied Appetite changes
☐ Reported ☐ Denied Marked weight change
☐ Reported ☐ Denied Night sweating
☐ Reported ☐ Denied Recent trauma or infection
☐ Reported ☐ Denied Sensitivity to heat or cold
☐ Reported ☐ Denied Tires easily
☐ Reported ☐ Denied Unusual weakness

Other

☐ Reported ☐ Denied ____________________
☐ Reported ☐ Denied ____________________

Head, Eyes, Ears, Nose and Throat

☐ Within Normal Limits

☐ Reported ☐ Denied Dizziness
☐ Reported ☐ Denied Headaches
☐ Reported ☐ Denied Nose bleeding
☐ Reported ☐ Denied Ringing in ears
☐ Reported ☐ Denied Sinus infections
☐ Reported ☐ Denied Sore gums or tongue
☐ Reported ☐ Denied Sore throat or hoarseness
☐ Reported ☐ Denied Swallowing difficulties
☐ Reported ☐ Denied Trauma
☐ Reported ☐ Denied Ulcers or lumps in mouth

Other

☐ Reported ☐ Denied ____________________
☐ Reported ☐ Denied ____________________

Lungs

☐ Within Normal Limits

☐ Reported ☐ Denied Persistent cough
☐ Reported ☐ Denied Shortness of breath
☐ Reported ☐ Denied Swelling of ankles
☐ Reported ☐ Denied Wheezing

Other

☐ Reported ☐ Denied ____________________
☐ Reported ☐ Denied ____________________

Heart

☐ Within Normal Limits

☐ Reported ☐ Denied High blood pressure

Other

☐ Reported ☐ Denied ____________________
☐ Reported ☐ Denied ____________________

Neurologic

☐ Within Normal Limits

☐ Reported ☐ Denied Dizziness

☐ Reported ☐ Denied Headaches ☐ Reported ☐ Denied Muscle weakness or paralysis

Other

☐ Reported ☐ Denied ____________________ ☐ Reported ☐ Denied ____________________

Reproductive

☐ Within Normal Limits

☐ Reported ☐ Denied Impotence

☐ Reported ☐ Denied Lack of sex drive

Other

☐ Reported ☐ Denied ____________________ ☐ Reported ☐ Denied ____________________

Other

☐ Within Normal Limits

Other

☐ Reported ☐ Denied ____________________ ☐ Reported ☐ Denied ____________________

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Patient Signature: ____ Date: ____________________

I certify that the medical history information is complete and accurate.

Patient Signature: ____ Date: ____________________

Version: SLPQV2

Sleep History/Exam/Workup Questionnaire

OFFICE USE
Patient ID:_____

NAME: ______________________________________ CURRENT DATE: ____/____/_______

DATE OF BIRTH: ___/___/______ ☐ MALE ☐ FEMALE

Referring Physician: ______________________________ Contact ID: ____________________

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

Number		Frequency	Intensity	Number		Frequency	Intensity
#1 = the most severe symptom		1-4	1-10	#1 = the most severe symptom		1-4	1-10
___ CPAP intolerance				___ Gasping causing waking up			
___ Difficulty concentrating				___ Insomnia			
___ Excessive daytime sleepiness				___ Nighttime choking spells			
___ Fatigue				___ Snoring which affects the sleep of others			
___ Forgetfulness				___ Witnessed cessation of breathing			
___ Frequent snoring							

Other: Write In: ________________________________

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No chance of dozing	**Slight** chance of dozing	**Moderate** chance of dozing	**High** chance of dozing	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	Sitting inactive in public place (e.g. a theater or a meeting)
☐	☐	☐	☐	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

Epworth Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations?

No chance of dozing	**Slight** chance of dozing	**Moderate** chance of dozing	**High** chance of dozing	
☐	☐	☐	☐	Sitting quietly after a lunch without alcohol
☐	☐	☐	☐	In a car, while stopped for a few minutes in traffic

SLEEP STUDIES

If you have had a Sleep Study, please check one of the following:

☐ Home Sleep Study ☐ Polysomnographic evaluation at a sleep disorder center

Sleep Center Name: ____

Sleep Study Date: ____/____/______

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of ______________________________

The evaluation showed:

		during REM	*Supine*	*Side*
an RDI of	_	_	_	_
an AHI of	_	_	_	_

a nadir SpO_2 of _ T90 _ ODI _ (Oxygen Desaturation Index)

Slow Wave Sleep ☐ Decreased ☐ None

REM Sleep ☐ Decreased ☐ None

Additional Questions

☐ Yes
☐ No
Are you a current CPAP (Continuous Positive Air Pressure) user?

If Yes, what are the current CPAP settings: ______________________________

CPAP Intolerance

(Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

☐ Refuses CPAP	☐ Noise disturbing sleep and/or bed partner's sleep	☐ Claustrophobic associations
☐ Mask leaks	☐ CPAP restricted movements during sleep	☐ An unconscious need to remove the CPAP
☐ Inability to get the mask to fit properly	☐ CPAP does not seem to be effective	☐ Does not resolve symptoms
☐ Discomfort from headgear	☐ Pressure on the upper lip causing tooth related problems	☐ Noisy
☐ Disturbed or interrupted sleep	☐ Latex allergy	☐ Cumbersome

CPAP Intolerance

(Continuous Positive Airway Pressure device)

Other

____________________ ____________________

Other Therapy Attempts

include:

- ☐ Dieting
- ☐ Weight loss
- ☐ Surgery (Uvuloplasty)
- ☐ Surgery (Uvulectomy)
- ☐ Pillar procedure
- ☐ Smoking cessation
- ☐ CPAP
- ☐ BiPAP
- ☐ Uvulectomy (but continues to have symptoms)
- ☐ Uvuloplasty (but continues to have symptoms)
- ☐ Positional therapy (side sleeping)
- ☐ Nasal strips

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____ ________________