

Comprehensive Questionnaire

Name: _____

Date: _____

Date of Birth: _____

Referring Physician: _____

Chief Complaints:

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

TMD/PAIN COMPLAINTS

- Back pain
- Difficulty swallowing
- Dizziness
- Ear congestion
- Ear pain
- Eye pain
- Facial pain
- Headaches
- Jaw clicking/Popping
- Jaw joint noises
- Jaw locking
- Jaw pain
- Limited mouth opening
- Migraines
- Morning head pain
- Muscle twitching
- Neck pain
- Nocturnal teeth grinding
- Pain when chewing
- Ringing in the ears
- Throat pain
- Shoulder pain
- Sinus congestion
- Visual disturbances

SLEEP BREATHING COMPLAINTS

- CPAP intolerance
- Difficulty falling asleep
- Fatigue
- Feeling unrefreshed upon waking
- Frequent heavy snoring
- Frequent heavy snoring which affects others
- Gasping when waking up
- Morning hoarseness
- Nighttime choking spells
- Significant daytime drowsiness
- Sleepy while driving
- Swelling in ankles or feet
- Witnessed apneic events

OTHER (Write in):

Signature: _____

Date: _____

Periodontal Questions:

- | | |
|---|--|
| <input type="checkbox"/> Do your gums ever bleed? | <input type="checkbox"/> Nutritional disorder |
| <input type="checkbox"/> Have your gums receded, or do your teeth look longer? | <input type="checkbox"/> Numbness of lower lip |
| <input type="checkbox"/> Have you ever been told that you have gum problems, including infection or inflammation? | <input type="checkbox"/> Numbness in jawbone |
| <input type="checkbox"/> Have you had any adult teeth extracted due to gum disease? | <input type="checkbox"/> Tingling in jawbone |
| <input type="checkbox"/> Diet limited to liquid foods | <input type="checkbox"/> Pain in jawbone |
| <input type="checkbox"/> Diet limited to semisolid or soft foods | <input type="checkbox"/> Pain when chewing |
| <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Pain when swallowing |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Poorly fitting dental appliance |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Swollen gums |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Sore or sensitive gums |
| <input type="checkbox"/> Gagging easily | <input type="checkbox"/> Other (please describe) |
| <input type="checkbox"/> Mouth sores | _____ |

Symptoms:

HEAD PAIN

L R B **Front of your head (Frontal)**

	<u>SEVERITY</u>			<u>FREQUENCY</u>			<u>DURATION</u>				
Mild	Moderate	Severe	Occasional	Frequent	Constant	Sec	Min	Hrs	Days	Wks	

L R B **Entire head (Generalized)**

	<u>SEVERITY</u>			<u>FREQUENCY</u>			<u>DURATION</u>				
Mild	Moderate	Severe	Occasional	Frequent	Constant	Sec	Min	Hrs	Days	Wks	

L R B **Top of your head (Parietal)**

	<u>SEVERITY</u>			<u>FREQUENCY</u>			<u>DURATION</u>				
Mild	Moderate	Severe	Occasional	Frequent	Constant	Sec	Min	Hrs	Days	Wks	

L R B **Back of your head (Occipital)**

	<u>SEVERITY</u>			<u>FREQUENCY</u>			<u>DURATION</u>				
Mild	Moderate	Severe	Occasional	Frequent	Constant	Sec	Min	Hrs	Days	Wks	

L R B **In your temples (Temporal)**

	<u>SEVERITY</u>			<u>FREQUENCY</u>			<u>DURATION</u>				
Mild	Moderate	Severe	Occasional	Frequent	Constant	Sec	Min	Hrs	Days	Wks	

Signature: _____

Date: _____

Symptoms, cont.:

JAW PAIN

- L R B Jaw pain – on opening
 L R B Jaw pain – while chewing
 L R B Jaw pain – at rest

JAW SYMPTOMS

- Jaw popping
 L R B Jaw clicking
 Jaw locks closed
 Jaw locks open
 Teeth grinding

MOUTH & NOSE RELATED CONDITIONS

- Burning tongue
 Frequent biting of cheek
 Frequent snoring
 Broken teeth
 Teeth clenching
 Dry mouth

EAR RELATED CONDITIONS

- Buzzing in the ears
 Tinnitus (ringing in the ears)
 Ear pain
 Ear congestion
 Pain in front of the ear
 Hearing loss
 Recurrent ear infections
 Pain behind the ear

EYE RELATED CONDITIONS

- Blurred vision
 Eye pain
 Pain or pressure behind the eyes

THROAT, NECK & BACK RELATED CONDITIONS

- Back pain - lower
 Back pain - middle
 Back pain - upper
 Chronic sore throat
 Constant feeling of a foreign object in throat
 Difficulty in swallowing
 Limited movement of neck
 Neck pain
 Numbness in the hands or fingers
 Sciatica
 Scoliosis
 Shoulder pain
 Shoulder stiffness
 Swelling in the neck
 Swollen glands
 Thyroid enlargement
 Tightness in the throat
 Tingling in the hands or fingers
 Chronic sinusitis
 Other (please describe)

Pain History:

Which side are the headaches worse?

- L R B

Headache spreads to:

- Back of head Neck
 Forehead Temples
 Back of head and Temples

SEVERITY ON A SCALE OF 0-10

(0=No pain 10=Worst pain imaginable)

- ___ Jaw pain ___ Neck pain
___ Headaches ___ Facial pain

Signature: _____

Date: _____

Pain History, cont.:

Frequency

- Occasional
- Frequent
- Constant

Duration

- Seconds Days
- Minutes Weeks
- Hours

When having pain you report:

- Dizziness
- Double Vision
- Fatigue
- Other (please describe) _____
- Nausea
- Sensitivity to light (photophobia)
- Sensitivity to noise

History of Symptoms:

Is there anything that makes your pain or discomfort worse? _____

Is there anything that makes your pain or discomfort better? _____

What other information is important regarding the pain or condition? _____

History of Treatment:

<u>Practitioner's Name</u>	<u>Specialty</u>	<u>Treatment</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature _____

Date _____

History of Accident:

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR TRAUMATIC INCIDENT RELATED TO THE CURRENT VISIT:

DATE OF ACCIDENT OR INCIDENT: _____

YOU BELIEVE THE CAUSE OF THE PAIN OR CONDITION TO BE: (SELECT ONE)

- | | |
|---|--|
| <input type="checkbox"/> A motor vehicle accident | <input type="checkbox"/> Hit by an object |
| <input type="checkbox"/> A motorcycle accident | <input type="checkbox"/> Hit an object |
| <input type="checkbox"/> A work related accident | <input type="checkbox"/> An illness |
| <input type="checkbox"/> A playground incident | <input type="checkbox"/> An injury |
| <input type="checkbox"/> An athletic endeavor | <input type="checkbox"/> Orthodontics |
| <input type="checkbox"/> A fight | <input type="checkbox"/> Dental procedures |
| <input type="checkbox"/> A fall | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> An accident | <input type="checkbox"/> Other (please describe) _____ |

WERE YOU: (SELECT ONE)

- | | |
|---|--|
| <input type="checkbox"/> A passenger in a motor vehicle | <input type="checkbox"/> Did you fall? |
| <input type="checkbox"/> The driver of a vehicle | <input type="checkbox"/> Were you hit by an object? |
| <input type="checkbox"/> A pedestrian | <input type="checkbox"/> Did you hit an object? |
| <input type="checkbox"/> At work | <input type="checkbox"/> Other (please describe) _____ |

IF IN A VEHICLE, WHERE WAS THE VEHICLE HIT?

- | | |
|--|---|
| <input type="checkbox"/> At the front end | <input type="checkbox"/> Head on |
| <input type="checkbox"/> At the rear end | <input type="checkbox"/> On driver's side |
| <input type="checkbox"/> At the front right area | <input type="checkbox"/> On passenger's side |
| <input type="checkbox"/> At the front left area | <input type="checkbox"/> Other area (please describe) _____ |
| <input type="checkbox"/> At the rear right area | _____ |
| <input type="checkbox"/> At the rear left area | _____ |

INDICATE IF THERE WAS ANY TRAUMA:

- | | |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Forehead | <input type="checkbox"/> Back of head |
| <input type="checkbox"/> Face | <input type="checkbox"/> Top of head |
| <input type="checkbox"/> Chin | <input type="checkbox"/> Teeth |
| <input type="checkbox"/> Side of head | <input type="checkbox"/> Jaw |

Forcibly Struck the:




- | | |
|--|--|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Driver's side door |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Headrest |
| <input type="checkbox"/> Passenger's side window | <input type="checkbox"/> Seat |
| <input type="checkbox"/> Driver's side window | <input type="checkbox"/> Roof |
| <input type="checkbox"/> Passenger's side door | <input type="checkbox"/> Interior of the car |

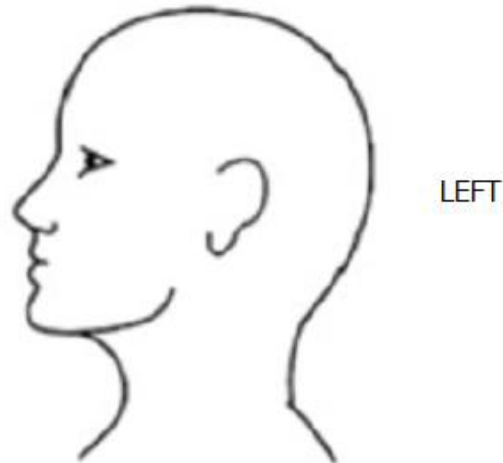
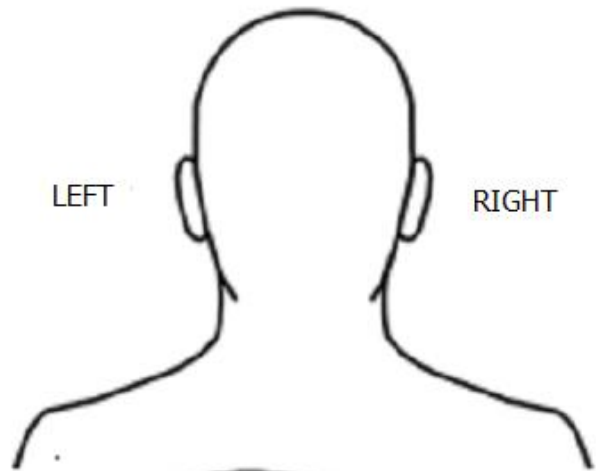
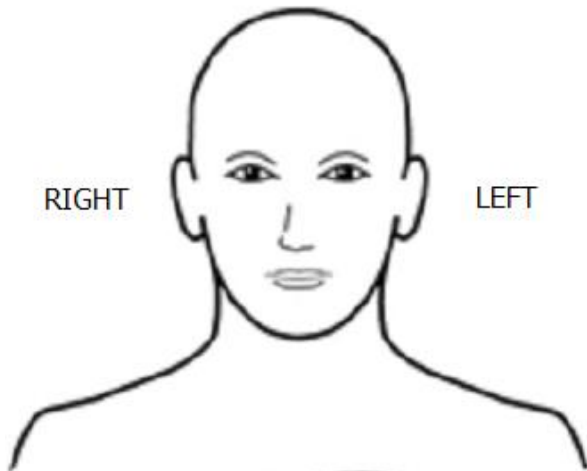
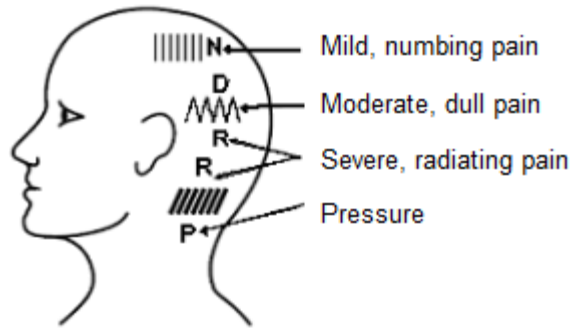
Signature: _____

Date: _____

Draw your pain patterns following this key:

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN		B Burning
		D Dull
		N Numbing
MODERATE PAIN		P Pressure
		S Sharp
SEVERE PAIN		T Tingling
		R Radiating



Signature: _____

Date: _____

Epworth Sleepiness Scale

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

No Chance of dozing 0	Slight Chance of dozing 1	Moderate Chance of dozing 2	High Chance of dozing 3	
				Sitting and reading
				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
				Sitting quietly after a lunch without alcohol
				In a car, while stopped for a few minutes in traffic

Total Score = _____

Fatigue Scale

<u>During the past week:</u>	<u>No <</u>							<u>>Yes</u>
	1	2	3	4	5	6	7	
I felt fatigued and had less motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued and did not desire to exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigue that interfered with my physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued which caused me frequent problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued which prevented sustained physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued and couldn't carry out certain duties & responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue was among my three most disabling symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue interfered with my work, family or social life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Total Score = _____							

Signature: _____

Date: _____

Sleep History:

Previous Diagnosis:

Have you been previously diagnosed with Obstructive Sleep Apnea? Yes No

If yes, how long ago was it? _____ Years Months Days ago

Are you a current CPAP/BiPAP user? Yes, current setting is _____ No

Snoring is reported as:

Frequency

- Seldom
- Never
- Daily
- Often

Severity

- Light
- Moderate
- Loud

Worse when sleeping on your back

Worse following alcohol late at night

Sleep:

Sleep Onset Latency _____ minutes

Sleep Aid Yes No

Normally goes to bed at _____ AM PM

If yes, name the medication: _____

Hours of sleep per night _____

Bruxism (grinding teeth)

of times per night you get up _____

Dry mouth

of times of nocturnal urination _____

Excessive movements

Gasping

Restless legs

Waking up and having difficulty returning to sleep

Dreaming

Witnessed apneas are:

Worse when sleeping on your back

Worse following alcohol

Wake:

Sleepiness while driving? Yes No

Naps: Daily Never Occasionally

Awakens unrefreshed

Has morning headaches

Sleep Studies:

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

Home Sleep Study Polysomnographic evaluation at a Sleep Disorder Center

Sleep Center Name: _____

Sleep Study Date: _____

Signature: _____

Date: _____

Other Therapy Attempts:

- | | |
|--|---|
| <input type="checkbox"/> Dieting | <input type="checkbox"/> CPAP |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> BiPAP |
| <input type="checkbox"/> Uvuloplasty | <input type="checkbox"/> Uvuloplasty (but continues to have symptoms) |
| <input type="checkbox"/> Uvulectomy | <input type="checkbox"/> Uvulectomy (but continues to have symptoms) |
| <input type="checkbox"/> Pillar procedure | <input type="checkbox"/> Positional therapy |
| <input type="checkbox"/> Smoking cessation | <input type="checkbox"/> Nasal strips |

CPAP Intolerance:

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

- | | |
|--|---|
| <input type="checkbox"/> Refuses CPAP | <input type="checkbox"/> Pressure on the upper lip causing tooth problems |
| <input type="checkbox"/> Mask leaks | <input type="checkbox"/> Latex allergy |
| <input type="checkbox"/> Inability to get the mask to fit properly | <input type="checkbox"/> Claustrophobic associations |
| <input type="checkbox"/> Discomfort from headgear | <input type="checkbox"/> An unconscious need to remove the CPAP |
| <input type="checkbox"/> Disturbed or interrupted sleep | <input type="checkbox"/> Does not resolve symptoms |
| <input type="checkbox"/> Noise disturbing sleep and/or bed partner's sleep | <input type="checkbox"/> Noisy |
| <input type="checkbox"/> CPAP restricted movements during sleep | <input type="checkbox"/> Cumbersome |
| <input type="checkbox"/> CPAP does not seem to be effective | <input type="checkbox"/> Other (please describe) _____ |

Orthodontic Concerns:

- | | |
|---|--|
| <input type="checkbox"/> Accident | <input type="checkbox"/> Receded jaw |
| <input type="checkbox"/> "Buck" or protruding teeth | <input type="checkbox"/> Tooth spacing - excessive |
| <input type="checkbox"/> Crowded teeth | TENDENCIES/HABITS |
| <input type="checkbox"/> Irregularly shaped teeth | <input type="checkbox"/> Clenching |
| <input type="checkbox"/> Mismatched bite | <input type="checkbox"/> Grinding |
| <input type="checkbox"/> Missing tooth | <input type="checkbox"/> Finger sucking |
| <input type="checkbox"/> Orthodontic second opinion | <input type="checkbox"/> Mouth breathing |
| <input type="checkbox"/> Overbite | <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Overly small mouth | <input type="checkbox"/> Tongue habit |
| <input type="checkbox"/> Prominent jaw | <input type="checkbox"/> Other (please describe) _____ |

Past Dental Experiences:

Past experience with dental treatments:

Signature: _____

Date: _____

Expanded Medical History

Allergens:

- | | | |
|---|--|---|
| <input type="checkbox"/> No Known Allergies | <input type="checkbox"/> Iodine | <input type="checkbox"/> Plastic |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Latex | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Sleeping Pills |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Metals | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> _____ |

Current Medications:

<u>Medicine</u>	<u>Dosage/Frequency</u>	<u>Reason</u>

Medical History

<u>Medical Condition</u>	<u>Never</u>	<u>Current</u>	<u>Past</u>	<u>Medical Condition</u>	<u>Never</u>	<u>Current</u>	<u>Past</u>
<input type="checkbox"/> Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Coronary Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Current Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bleeding Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blood Pressure-High	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blood Pressure – Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bruising Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature: _____

Date: _____

Medical History, cont.:

<u>Medical Condition</u>	<u>Never</u>	<u>Current</u>	<u>Past</u>	<u>Medical Condition</u>	<u>Never</u>	<u>Current</u>	<u>Past</u>
<input type="checkbox"/> Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Excessive Daytime Sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Nasal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Prior Orthodontic Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sinus Problems			
<input type="checkbox"/> Immune System Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ischemic Heart Disease (reduced blood supply)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Tendency for Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Meniere's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Urinary Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (please describe) _____							

Surgical Operations:

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Heart	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Back	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Ear	<input type="checkbox"/> Lung	<input type="checkbox"/> Uvulectomy
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Nasal	<input type="checkbox"/> Periodontal
<input type="checkbox"/> Other (please describe) _____		

Signature: _____

Date: _____

Family History:

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Father Snores |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Mother Snores |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Obesity | <input type="checkbox"/> Father has Sleep Apnea |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Mother has Sleep Apnea |

Social History:

Occupation: _____ Employer: _____

Tobacco Use:

Cigarettes: Never Smoked Current Smoker Quit
of packs per day _____ When did you quit? ____
of years _____

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: _____

Exercise:

Do you exercise regularly? Yes No

Because of HIPPA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner, as required, including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not reimbursed by insurance and that insurance submittal is provided as a courtesy to you. Your dental practitioner may use your health care information and may disclose such information to your insurance company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

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

Signature: _____ Date: _____

Signature: _____

Date: _____