Patient Information And Medical History

DENTAL ASSOCIATES
SLEEP SOLUTIONS

Patient Information

Today's Date: _____

Last Name: _____ First Name: _____ MI:_____

Birth date: _____ Age: _____ Sex: ☐M ☐F

Address: Street_____ City_____ State_____ Zip_____

Best phone # to reach you: _____ Alternative phone #: _____

E-mail address:_____

Martial Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Height (In.) _____Current Weight (#) _____Weight 5 years ago (#) _____Peak Weight(#)_____

Employer: _____ Occupation: _____

Emergency Information:

Emergency Contact: _____ Relationship: _____

Contact Number: _____ Alternative Number: _____

Health Care Providers:

Referring Sleep Physician: _____

Primary Care Physician: _____

Dentist of Record: _____

PATIENT CHIEF COMPLAINT: Briefly describe your problem with your sleep as you see it:

PATIENT EXPECTATION: What is the nature of assistance you expect or desire?

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Birthdate:_____

Have You Had Any Of The Following?

Constitutional	Yes	No
Unexplained appetite changes	☐	☐
Unusual weakness	☐	☐
Recent trauma	☐	☐
Recent infection	☐	☐
Tire easily	☐	☐
Recent marked weight changes	☐	☐
Sensitivity to heat or cold	☐	☐
Night sweats	☐	☐
Head		
Chronic facial pain	☐	☐
Chronic headache pain		
— Daytime	☐	☐
— Nighttime	☐	☐
Neck		
Neck pain	☐	☐
Swelling	☐	☐
Stiffness	☐	☐
Eyes		
Double vision	☐	☐
Blurred vision	☐	☐
Ears		
Stuffiness in ears	☐	☐
Ringing in ears	☐	☐
Discharge	☐	☐
Ear Pain	☐	☐
Ear pain		
Nose		
Change of smell		
(Not associated with illness)	☐	☐
Nasal obstruction		
(Not associated with illness)	☐	☐
Excessive sneezing	☐	☐
Nasal allergies	☐	☐
Nose bleeds	☐	☐
Frequent sinus infections	☐	☐
Throat		
Chronic soreness	☐	☐
Chronic hoarseness	☐	☐
Difficulty swallowing	☐	☐

Cardiovascular	Yes	No
Chest pain	☐	☐
High blood pressure	☐	☐
Chest tightness	☐	☐
Swelling of ankles	☐	☐
Palpitations	☐	☐
Respiratory		
Persistent cough	☐	☐
Labored breathing	☐	☐
Hard to breath laying down	☐	☐
Yellow or green sputum	☐	☐
Wheezing	☐	☐
Gastrointestinal		
Unexplained nausea	☐	☐
Chronic diarrhea	☐	☐
Chronic constipation	☐	☐
Heartburn	☐	☐
Genitourinary		
Loss of libido:	☐	☐
Women:		
Pre-menopausal	☐	☐
Peri-menopausal	☐	☐
Post-menopausal	☐	☐
Could you be pregnant?	☐	☐
Musculoskeletal		
Pain in joints	☐	☐
Joint injections	☐	☐
Joint or muscle pain that alters sleep position	☐	☐
Endocrine		
Thyroid condition	☐	☐
Adrenal condition	☐	☐
Cortisone treatments	☐	☐
Hot flashes	☐	☐
Are you nursing?	☐	☐
Neurological		
Loss of memory	☐	☐
Disorientation	☐	☐
Fainting	☐	☐
Dizziness	☐	☐
Vertigo	☐	☐
Clumsiness	☐	☐
Muscle paralysis	☐	☐
Muscle weakness	☐	☐

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Birthdate:_____

Medical History

	Yes	No	Year		Yes	No	Year
Upper Airway Resistance Syndrome	☐	☐	_____	Depression	☐	☐	_____
Obstructive Sleep Apnea	☐	☐	_____	Anxiety Disorder	☐	☐	_____
Snoring	☐	☐	_____	ADHD	☐	☐	_____
High Blood Pressure	☐	☐	_____	Arthritis	☐	☐	_____
Heart Attack Stroke	☐	☐	_____	Kidney Disease	☐	☐	_____
High Cholesterol	☐	☐	_____	Tuberculosis	☐	☐	_____
Atrial Fibrillation	☐	☐	_____	Pneumonia	☐	☐	_____
Heart Disease	☐	☐	_____	Pulmonary Disease	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Asthma	☐	☐	_____
Obesity	☐	☐	_____	Epilepsy	☐	☐	_____
Diabetes Type I	☐	☐	_____	Bleeding Tendency	☐	☐	_____
Diabetes Type II	☐	☐	_____	Cancer	☐	☐	_____
Acid Reflux (GERD)	☐	☐	_____	Fibromyalgia	☐	☐	_____
Hepatitis/Liver Disease	☐	☐	_____	HIV/Aids	☐	☐	_____
				Any other illnesses: _____			

Surgical History

	Yes	No	Year		Yes	No	Year
Gall Bladder Removal	☐	☐	_____	Wisdom Tooth Extraction	☐	☐	_____
Appendectomy	☐	☐	_____	Extraction history with Orthodontics	☐	☐	_____
Hysterectomy	☐	☐	_____	Nasal Surgery	☐	☐	_____
Back Surgery	☐	☐	_____	Tonsillectomy	☐	☐	_____
Shoulder Surgery	☐	☐	_____	Adenoidectomy	☐	☐	_____
Hernia Repair	☐	☐	_____	Surgery for snoring or sleep apnea	☐	☐	_____
Heart Surgery	☐	☐	_____	Any other surgeries:_____			
Thyroid Surgery	☐	☐	_____	_____			

Has Any Blood Relative Had Any Of The Following?

(Father, Mother, Sister, Brother, Uncle, Aunt, Grandma, Grandpa, Daughter, Son)

	Yes	No	Relationship		Yes	No	Relationship
Snoring	☐	☐	_____	Diabetes Type I	☐	☐	_____
Obstructive Sleep Apnea	☐	☐	_____	Diabetes Type II	☐	☐	_____
Heart Disease	☐	☐	_____	Acid Reflux	☐	☐	_____
High Blood Pressure	☐	☐	_____	Depression	☐	☐	_____
Heart Attack	☐	☐	_____	Obesity	☐	☐	_____
High Cholesterol	☐	☐	_____	Asthma	☐	☐	_____
Stroke	☐	☐	_____	Severe Allergies	☐	☐	_____

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Birthdate:_____

Pre-medications

Have you been told that you should receive pre-medication before dental procedures? Yes ☐ No ☐

If Yes, what medication(s) and why do you require it?_____

Drug and Other Allergies

Allergic

- ☐ **Penicillin** such as Penicillin VK, Penicillin G, Dicloxacillin, Oxacillin, Nafcillin, Amoxicillin, Ampicillin, Augmentin (amoxicillin/clavulanate)
- ☐ **Sulfa** such as Sulfa antibiotics, Sulfonylureas (Diabetes), Celebrex, Imitrex, Zonisamide
- ☐ **Cephalosporins** such as Keflex (cephalexin), Ancef (cefazolin), Ceftin (cefuroxime) Cefzil (cefprozil), Omnicef (cefdinir), Vantin (cefpodoxime)
- ☐ **Non-Steroidal Anti-Inflammatory Drugs** (NSAID), including aspirin, ibuprofen and naproxen
- ☐ **Latex**
- ☐ **Other:**

Medication List

Medication Name	Dose (mg, drops, etc.)	When Taken (daily, at bedtime, etc.)	Reasons for Taking (blood pressure, diabetes, etc.)

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Patient Last Name:_____ First:_____ Date:_____
Birthdate:_____

Social History

Tobacco Use: Yes No

Do you smoke tobacco? ☐ ☐

If yes, how much per day? _____

How long have you smoked? _____

If you smoke tobacco, do you smoke when you wake up during the night? ☐ ☐
If you smoke, have you noticed that nicotine alters or interferes with your sleep? ☐ ☐

Non-Alcoholic Beverages:

Do you usually drink coffee, tea, chocolate, cola, or other caffeinated beverages within 3 hours of your bedtime? ☐ ☐

How much of the following do you consume in a usual day?

Coffee/Tea _____ Cola _____ Chocolate _____ Other _____

Alcoholic Beverages:

Do you drink alcoholic beverages ☐ ☐

Assuming the following drinks are equivalent-12oz.beer /5 oz. wine /3oz vodka, etc. - then:

How many drinks do you have in a usual weekday? _____

On a weekend or holiday? _____

Do you drink alcohol within two hours of bedtime? ☐ ☐
Do alcoholic beverages alter or interfere with your sleep? ☐ ☐
Have you ever used alcohol in order to get to sleep? ☐ ☐
Have you ever sought treatment/counseling for an alcohol problem? ☐ ☐
If yes Date: _____

Sedatives:

Do you take sedatives before bed time (over the counter or prescribed) to help you fall a sleep? ☐ ☐

If yes, what do you take? _____

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DENTAL ASSOCIATES
SLEEP SOLUTIONS

Patient Last Name:_____ First:_____ Date:_____
Birthdate:_____

Dental and TMJ History

How would you describe your dental health? Excellent/ Good/ Fair/ Poor

Yes	No	
☐	☐	Have you ever had teeth extracted
☐	☐	Do you wear a removable partial denture
☐	☐	Do you wear a full denture
☐	☐	Have you ever worn braces
☐	☐	Nocturnal bruxism
☐	☐	Nocturnal clenching
☐	☐	Daytime clenching
☐	☐	Previous use of occlusal splint for nocturnal habit
☐	☐	Current use of occlusal splint for nocturnal habit
☐	☐	Have you ever had gum problems
☐	☐	Have you ever had gum surgery
☐	☐	Do you have dry mouth
☐	☐	Have you ever had an injury to the head, face, neck, or mouth

If yes, please describe: _____

☐ ☐ Are you planning to have dental work in the near future

If yes, please describe: _____

Yes	No	
☐	☐	History of joint locking
☐	☐	Clicking in right joint
☐	☐	Clicking in left joint
☐	☐	Joint pain ☐ R ☐ L
☐	☐	Headaches caused by TMD
☐	☐	Facial muscle pain
☐	☐	Have you had TMJ surgery

Sleep History

Sleep Hygiene

Do you have a regular sleep schedule ☐ Yes ☐ No

What time is your usual bed time? ☐ 8:00-9:00PM ☐ 9:00-10:00PM ☐ 10:00-11:00PM
☐ 11:00-12:00AM ☐ after 12:00AM

How long does it take you to sleep? ☐ less than 20 min ☐ 20-40 min ☐more than 40 min

What time do you wake up? ☐ before 5:00AM ☐ 5:00-6:00AM ☐ 6:00-7:00AM ☐ 7:00-8:00AM
☐ 8:00-9:00AM ☐ After 9:00AM

Do you wake ☐ refreshed ☐ unrefreshed

	Yes	No
Do you nap easily	☐	☐
Do you wake up more than once on most nights	☐	☐
Get up to urinate	☐	☐
Difficulty falling back to sleep after awaking during the night	☐	☐
Do you snore	☐	☐
If yes, is it: ☐ Soft ☐ Loud ☐ Very Loud ☐ Don't know		
Snoring affecting the sleep of others	☐	☐

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Patient Last Name:_____ First:_____ Date:_____
Birthdate:_____

Sleep History (cont.)

	Yes	No
Has anyone witnessed you stop breathing in your sleep	☐	☐
Nighttime mouth breathing	☐	☐
Dry mouth when waking up	☐	☐
Nighttime nasal congestion	☐	☐
Restless Legs	☐	☐
Do you have morning headaches	☐	☐
Eat within 2 hours of bedtime	☐	☐
Do you experience heartburn at night	☐	☐
Excessive daytime sleepiness	☐	☐
Does daytime sleepiness affecting your quality of life	☐	☐
Any history of car accidents or near miss car accidents due to drowsiness	☐	☐
Do you have decrease ability to concentrate or forgetfulness	☐	☐
Do you use a TV, radio, computer, cell phone, or tablet prior to sleep	☐	☐

Have you been evaluated at a sleep disorders center before? ☐ ☐
If yes, When (Date) _____ Where? _____

What were you told the problem was?_____

What treatment were you given? _____

Why are you being evaluated again? _____

Have you had any oral surgeries to treat your sleep symptoms?	☐	☐
Do you work varying shifts or nighttime shifts?	☐	☐
Are you open to surgical treatment of your sleep symptoms at this time?	☐	☐
Are you currently wearing a dental device to treat snoring/apnea?	☐	☐
Have you previously tried a dental device for treatment of snoring/apnea?	☐	☐
If yes to the above question, was it an Over the Counter (OTC)?	☐	☐
Was it fabricated by a dentist?	☐	☐
If yes, who fabricated it?_____		
Have you had a sleep test with the device	☐	☐

If applicable, please describe your previous dental device experience:

Any additional comments or concerns related to your sleep?

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Birthdate:_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following circumstances, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Situation:	Scale:
Sitting and reading	
Watching television	
Sitting inactive in a public place (i.e. a theater)	
A passenger in a car for an hour without a break	
Lying down to rest in the afternoon when possible	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car while stopped for a few minutes in traffic	
Total	
Overall quality of sleep-poor, avg, good	

Scale:

- **0** - Would Never Fall Asleep
- **1** - Slight Chance of Dozing
- **2** - Moderate Chance of Dozing
- **3** - High Chance of Dozing

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Affidavit of Intolerance to CPAP

Patient Name: _____

I □ have □ have not attempted to use nasal CPAP to manage my sleep disordered breathing (obstructive sleep apnea).
If you currently use a CPAP, how many nights per week do you ware it? _____/7 nights
When you ware your CPAP, how many hours per night do you ware it? _____ hours per night

If you find the CPAP intolerable to use on a regular basis, please indicate the your reason(s):

- □ I am unable to sleep with CPAP equipment in place
- □ The noise from the device disturbs my sleep or my bed partner's sleep
- □ I cannot find a comfortable mask
- □ The mask leaks
- □ I develop sinus / throat / ear / lung infections
- □ I am allergic to materials in the mask and head straps
- □ Claustrophobia
- □ I unconsciously remove the CPAP apparatus at night
- □ The pressure of the mask and straps cause tissue breakdown
- □ My job and/or lifestyle prevent this form of therapy (e.g. Active Army / National Guard duty)
- □ Prior throat surgery made CPAP intolerable.
- □ *****Refused to attempt CPAP usage
- □ ******CPAP was ineffective in controlling my symptoms
- □ Other

Because of my inability to tolerate CPAP and my need to control the signs and symptoms of OSA, I wish to use an alternative method of treatment. This form of therapy is oral appliance therapy (OAT).

Signed:_____ Date_____