Patient Health History

Patient Name: ________________________________ Male: ☐ Female: ☐ DOB: ____/____/____

Race/Ethnicity:

Caucasian ☐ Latino or Hispanic ☐ Black or African American ☐ Middle Eastern ☐ South Asian ☐ East Asian ☐

Native American or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐

General Health History

Do you have any of the following conditions: (Select all that apply)

- ADD/ADHD ☐
- Anxiety ☐
- Depression ☐
- Autism ☐
- Mental Health Problems ☐
- Thyroid Condition ☐
- Cancer ☐
- Hayfever/Seasonal Allergies ☐
- Chronic Sinusitis/Sinus Congestion ☐
- Asthma ☐
- Shortness of breath ☐
- Chronic Obstructive Pulmonary Disease ☐
- Difficulty Swallowing ☐
- Acid Reflux/Heartburn ☐
- Stomach Ulcers ☐
- Irritable Bowel Syndrome ☐
- Diabetes ☐
- High Cholesterol ☐
- High Blood Pressure/Hypertension ☐
- Heart Rhythm Abnormalities ☐
- Cardiac Pacemaker ☐
- Heart Valve Replacement ☐
- Heart Disease ☐
- History of Heart Attack ☐
- History of Stroke ☐
- Blood Clotting Problems ☐
- Blood Disorders ☐
- Hepatitis ☐
- Liver Disease ☐
- Fever Blisters/Herpes ☐
- Aids/HIV Infection ☐
- Tuberculosis ☐
- Other Contagious Disease ☐
- Kidney/Bladder Trouble ☐
- Sexual Problems ☐
- Dry Mouth/Dry Eyes ☐
- Gum (periodontal) Disease ☐
- Fainting Spells/Seizures ☐
- Epilepsy ☐
- Join Replacement ☐
- Trauma/Injury to Face ☐
- Tinnitus (Ringing in the ears) ☐
- TMJ Pain ☐
- Fibromyalgia/Chronic Body Pain ☐
- Chronic Neck Pain ☐

Headaches

Do you have chronic headaches? Yes ☐ No ☐

If yes, how often ________________

What triggers the headache? ________________

What relieves headache? ________________

Describe headache: Dull ☐ Aching ☐ Thunderclap ☐ Sharp ☐

What part of the head? Forehead ☐ Behind eyes ☐ One Side only ☐ Sides of the head ☐ Top of the Head ☐

Allergies

- Latex ☐
- Metal ☐
- Acrylic ☐
- Contrast Dye ☐
- Pain Medications ☐
- Plastic ☐
- Food ☐
- Antibiotics ☐

List all allergies (including those to medications):

____

____

____

Sleep Health History

Do you have any of the following conditions: (Select all that apply)

- Snoring ☐
- Central Sleep Apnea ☐
- Insomnia ☐
- Restless Leg Syndrome ☐
- Sleep Walking ☐
- Night Terrors ☐
- Obstructive Sleep Apnea ☐
- Excessive Daytime Sleepiness ☐
- Narcolepsy ☐
- Periodic Limb Movement ☐
- Bed Wetting ☐
- Circadian Rhythm Disorder ☐

Have you ever had a sleep study? Yes ☐ No ☐

Approximate date of most recent sleep study: ________________

Location of most recent sleep study: ________________

Have you currently or previously used any of the following treatments for OSA?

	Current	Past
Mandibular Advancement Device	☐	☐
Hypoglossal nerve stimulation (INSPIRE)	☐	☐
CPAP	☐	☐
Myofunctional Therapy	☐	☐
Airway Surgery		☐
Tongue Tie Release (frenectomy)		☐

Care Providers

Do you have a Primary Care Provider (including Pediatrician)?

Yes ☐ No ☐

If yes:

Name of Primary Care Provider ________________

Location of Primary Care Provider ________________

Do you have a Sleep Specialist or ENT?

Yes ☐ No ☐

If yes:

Name of Sleep Specialist or ENT ________________

Location of Sleep Specialist or ENT ________________

Medication

Do you take any of the following medication types at least once a week?

- Blood pressure medication ☐
- Pills for diabetes ☐
- Depression medication ☐
- ADHD medication/stimulants ☐
- Sexual function stimulant ☐
- Thyroid medication ☐
- Antihistamine or steroid for nasal congestion ☐
- Chemotherapy agents (IV or oral) ☐
- Sleeping medication ☐
- Insulin ☐
- Pain medication ☐
- Anxiety medication ☐
- Bladder urge suppressant ☐
- Cannabinoids (THC or CBD) ☐
- Home Oxygen ☐

List any additional medications (prescriptions, OTC, herbal supplements):

____

____

Are you required to pre-med with antibiotics before dental treatment?

Yes ☐ No ☐

Surgeries/Hospitalizations

Have you had any surgery on the following body parts or types?

Nose	☐	Weight Loss Surgery	☐	Neck	☐
Tongue	☐	Sinus	☐	Lungs	☐
Palate/Lips	☐	Jaw	☐	Brain	☐
Back (spine)	☐	Tonsils/Throat	☐	TMJ	☐
Sleep Apnea	☐	Adenoids Removed	☐	Teeth	☐

List ALL previous surgeries or procedures below (include year):

Are you planning on any upcoming surgeries or procedures? Yes ☐ No ☐

Details: ______________________

Have you been hospitalized within the past 5 years? Yes ☐ No ☐

If yes, what illness or problem? ______________________

Dental & Orthodontics

Are you planning on any upcoming dental work? Yes ☐ No ☐

Details of upcoming dental work: ______________________

Are you currently undergoing any orthodontic treatment? Yes ☐ No ☐

Name of orthodontist or specialist ______________________

Location of orthodontist or specialist ______________________

Have you undergone orthodontics in the past (i.e. braces, aligners, expanders, etc.)? Yes ☐ No ☐

If Yes: How many times? Once ☐ Twice ☐ 3 or more ☐

Have you ever had IPR (slimming teeth in ortho)? Yes ☐ No ☐

Have you ever had headgear? Yes ☐ No ☐

Were permanent teeth removed as part of your orthodontics Yes ☐ No ☐

Family & Social

Family History (Select all that Apply)

High Blood Pressure	☐	Heart Disease	☐
Diabetes	☐	Obesity	☐
Cancer	☐	Stroke	☐
Snoring	☐	Sleep Apnea	☐
Insomnia	☐	Restless Leg Syndrome	☐
Anxiety	☐	Depression	☐

Family History Details: ______________________

Are you a current or former smoker? Yes ☐ No ☐ Current ☐

How many packs per week? ______________________

Do you consume alcohol? Yes ☐ No ☐

How many drinks per week? ______________________

Do you regularly consume caffeine or sugary drinks? Yes ☐ No ☐

Type of caffeine/sugary drink and how often? ______________________

Marital Status

Married	☐	Widowed	☐
Single	☐	Separated	☐
Divorced	☐	Domestic Partner	☐

Who sleeps in the same room with you (select all that apply)?

Spouse	☐	Other family member	☐
Partner	☐	I sleep alone	☐
Roommate	☐	Pet	☐

Do you have pets? Yes ☐ No ☐

If yes, how many and what type of pets? ______________________

Are you pregnant or planning to become pregnant? Yes ☐ No ☐

If yes, when is your due date? ______________________

Are you currently breastfeeding? Yes ☐ No ☐

Do you have children? Yes ☐ No ☐

If yes, how many children do you have? ______________________

Was your child breast-fed? Yes ☐ No ☐

If yes, how long was your child breast fed? ______________________

Patient Dental History

When was your last dental visit? ______________________

Date of last radiographs (x-rays): ______________________

How many dentists have you seen in the last 5 years?

0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐

What is your immediate dental need? ______________________

Rate your smile from 1-10 (1= Dissatisfied, 10 happy) ______________________

What aspect of your smile would most like to correct?

____

Has anything prevented you from addressing this concern in the past?

____

Does dental treatment make you nervous?

Extremely ☐ Moderately ☐ Slightly ☐ No ☐

Have you ever had your teeth whitened in the past, including over-the-counter products?

Yes ☐ No ☐

If Yes, please explain: ______________________

Do you have any of the following?

Bleeding gums	☐	Food impactions	☐	Orthodontic treatment	☐
Loose teeth	☐	Sensitivity to pressure	☐	Unpleasant taste/bad breath	☐
Sensitivity to cold	☐	Bite your cheeks/lips	☐	Gum recession	☐
Sensitivity to heat	☐	Difficulty opening or closing jaw	☐	Gum disease	☐
Burning tongue/lips	☐	Clicking/popping in the jaw	☐	Teeth removed for braces	☐
Swelling or lumps in the mouth	☐	Clenching or grinding	☐	Wisdom teeth removed	☐
Frequent blisters on lip/mouth	☐	Change in bite or multiple bites	☐	Change in teeth shape/length	☐
Sensitivity to sweets	☐	Shifting teeth	☐		

Other: ______________________

How often do you brush? ______________________

Your toothbrush is:

Soft ☐ Medium ☐ Hard ☐

Do you use the following?

Manual toothbrush	☐	Dental Floss	☐	Breath mints/Altoids	☐
Electric toothbrush	☐	Mouthwash	☐	Fluoride Rinse	☐