History

First and Last Name: _____

Date of Birth: _____

Medical History

Select each condition or treatment in the lists below that you currently or previously have experienced. If you do not have any previous or current history pertaining to a specific list, select NONE. If there are other items not listed, select OTHER and provide any details on the lines labeled Additional Medical History at the bottom of this section.

Medical Conditions:

- ☐ **Snoring**
- ☐ **Periodic Limb Mvmt. Dis.**
- ☐ **Narcolepsy**
- ☐ **Heart Failure**
- ☐ **Chronic Fatigue**
- ☐ **Heartburn (acid reflux)**
- ☐ **Migraines**
- ☐ **Obesity**
- ☐ **High Blood Pressure**
- ☐ **Nasal Congestion/Blockage**
- ☐ **NONE**
- ☐ **Obstructive Sleep Apnea**
- ☐ **Restless Leg Syndrome**
- ☐ **Heart Disease**
- ☐ **COPD**
- ☐ **Cancer**
- ☐ **Depression**
- ☐ **ADD/ADHD**
- ☐ **Arthritis**
- ☐ **Nasal Polyps**
- ☐ **Alzheimer's**
- ☐ **OTHER**
- ☐ **Central Sleep Apnea**
- ☐ **Insomnia**
- ☐ **Heart Arrhythmia**
- ☐ **Diabetes**
- ☐ **Stroke**
- ☐ **Morning Headaches**
- ☐ **Anxiety**
- ☐ **Chronic Sinusitis**
- ☐ **Deviated Septum**
- ☐ **Supplemental Oxygen**

Treatments Attempted to Improve Sleep:

- ☐ **Oral Appliance**
- ☐ **Uvuloplasty**
- ☐ **Limiting Caffeine/Alcohol**
- ☐ **NONE**
- ☐ **CPAP**
- ☐ **Nasal Surgery**
- ☐ **Rapid Maxillary Expansion**
- ☐ **OTHER**
- ☐ **Weight Loss**
- ☐ **Sleeping Medication**
- ☐ **Removal of Adenoids**

Family History:

- ☐ **Diabetes**
- ☐ **Obesity**
- ☐ **Stroke**
- ☐ **OTHER**
- ☐ **Heart Disease**
- ☐ **Other Sleep Disorder**
- ☐ **Dementia/Alzheimer's**
- ☐ **High Blood Pressure**
- ☐ **Obstructive Sleep Apnea**
- ☐ **NONE**

Social History:

- ☐ **Current Smoker**
- ☐ **Travels Frequently**
- ☐ **Drinks Caffeine Regularly**
- ☐ **NONE**
- ☐ **Uses Oral Tobacco**
- ☐ **Uses Marijuana**
- ☐ **Ex-Smoker**
- ☐ **OTHER**
- ☐ **Drinks Alcohol Regularly**
- ☐ **Has Pets At Home**
- ☐ **Uses Recreational Drugs**

In each of the spaces below, list any previous surgeries (including the year) and all current medicaitons you are taking. If you have not had any surgeries or do not take medications, indicate with “n/a”.

Previous Surgeries:

_____

_____

_____

_____

Current Medications:

_____

_____

_____

_____

Answer each question below. If “yes” provide details on the line to the right.

Do you have allergies to any medications?

☐ **Yes** ☐ **No**

Do you suffer from seasonal/environmental allergies?

☐ **Yes** ☐ **No**

Do you see a physicians or other provider for sleep problems?

☐ **Yes** ☐ **No**

Have you ever had a sleep study?

☐ **Yes** ☐ **No**

Do you have a Primary Care Provider?

☐ **Yes** ☐ **No**

Medication Allergies:

_____

Other Allergies (details):

_____

Sleep Physicians (name):

_____

Location and Year of most recent Sleep Study:

_____

Primary Care Provider (name):

_____

Additional Medical History:

_____

_____

_____

_____

Dental History

Select each condition or treatment in the lists below that you currently or previously have experienced. If you do not have any previous or current history pertaining to a specific list, select NONE. If there are other items not listed, select OTHER and provide any details on the lines labeled Additional Dental History at the bottom of this section.

Dental & Oral Health:

- ☐ **Tooth Pain or Sensitivity**
- ☐ **Gingivitis**
- ☐ **Oral Cancer**
- ☐ **Trouble Swallowing**
- ☐ **Mis-alignment of Jaw**
- ☐ **Periodontal Disease**
- ☐ **OTHER**
- ☐ **Tooth Decay/Abcess**
- ☐ **Cold/Canker Sores**
- ☐ **Severe Gag Reflex**
- ☐ **TMJ/Jaw Pain**
- ☐ **Trauma to Face or Mouth**
- ☐ **Dry Mouth**
- ☐ **Extracted/Missing Teeth**
- ☐ **Oral Thrush (Candidiasis)**
- ☐ **Disease of the Throat**
- ☐ **Clenching/Grinding**
- ☐ **Cleft Palate / Cleft Lip**
- ☐ **NONE**

Dental Treatments:

- ☐ Bite Guard
- ☐ Complete Dentures
- ☐ Currently Wearing Braces
- ☐ OTHER
- ☐ Dental Implants
- ☐ Dental Arch Reconstruction
- ☐ Currently Wearing Invisalign
- ☐ Partial Dentures
- ☐ Tooth Extraction
- ☐ NONE

Answer each question below. If “yes” provide details on the line to the right.

Do you have a current dentist?

☐ Yes ☐ No

Current Dentist (name): _____

Do you stay current on regular dental cleanings?

☐ Yes ☐ No

Last Dentisit Visit (year): _____

Are you planning any upcoming dental work?

☐ Yes ☐ No

Upcoming/Planned Dental Work (details): _____

Do you have a sensitivity to latex, acrylic or metal?

☐ Yes ☐ No

Sensitivity Details: _____

Ever had problems wearing oral device (appliance, retainer, bite guard)?

☐ Yes ☐ No

Problem Details: _____

Additional Dental History:

_____

_____

_____

_____

Review of Systems

Please answer each of the following questions about your current health:

Do you have difficulty sleeping?

☐ Yes ☐ No

Do you often feel tired or fatigued?

☐ Yes ☐ No

Have you experienced any recent weight gain/ loss?

☐ Yes ☐ No

Do you have any current heart problems?

☐ Yes ☐ No

Do you have TMJ or jaw pain?

☐ Yes ☐ No

Do you have any problems with your gums or mouth?

☐ Yes ☐ No

Do you have any problems with your throat?

☐ Yes ☐ No

Do you have any current respiratory problems?

☐ Yes ☐ No