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

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

List all allergies (including those to medications):

_____

_____

_____

Sleep Health History

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

Snoring	☐	Obstructive Sleep Apnea	☐
Central Sleep Apnea	☐	Excessive Daytime Sleepiness	☐
Insomnia	☐	Narcolepsy	☐
Restless Leg Syndrome	☐	Periodic Limb Movement	☐
Sleep Walking	☐	Bed Wetting	☐
Night Terrors	☐	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	☐	Chemotherapy agents (IV or oral)	☐
Pills for diabetes	☐	Sleeping medication	☐
Depression medication	☐	Insulin	☐
ADHD medication/stimulants	☐	Pain medication	☐
Sexual function stimulant	☐	Anxiety medication	☐
Thyroid medication	☐	Bladder urge suppressant	☐
Antihistamine or steroid for nasal congestion	☐	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 ☐

Patient Health History

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	☐