



PATIENT NAME: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

1. Are you allergic to any medicines, latex, eggs, or soybeans? *List any medication and reaction to medication.* _____ YES NO
2. Do you take any medications (prescription or over-the-counter), supplements, or herbal therapy regularly now? *List name, strength, & frequency of current medications:* _____
_____ YES NO
3. Have you been a patient in a hospital during the past 2 years? YES NO
4. Are you now or have you been under the care of a physician during the past 2 years? YES NO
5. Have you ever had any type of surgery? *Please list:* _____
_____ YES NO
6. Have you had excessive bleeding requiring Special treatment? YES NO
7. Are you pregnant? YES NO
8. Have you ever had an artificial joint placed? YES NO
9. Do you get regular exercise? YES NO
10. Do you use or have you used tobacco products? YES NO
11. Do you use recreational drugs? YES NO
12. Do you drink alcohol? (Number of drinks per week _____) YES NO

CHECK YES OR NO AS TO WHETHER YOU NOW OR IN THE PAST HAVE HAD PROBLEMS WITH AND/OR TREATMENT FOR:

- | | | |
|---|--|---|
| <input type="radio"/> YES <input type="radio"/> NO Heart Trouble | <input type="radio"/> YES <input type="radio"/> NO Jaundice | <input type="radio"/> YES <input type="radio"/> NO Chemo / Radiation |
| <input type="radio"/> YES <input type="radio"/> NO Asthma | <input type="radio"/> YES <input type="radio"/> NO Kidney Disease | <input type="radio"/> YES <input type="radio"/> NO Chronic Fatigue |
| <input type="radio"/> YES <input type="radio"/> NO Arthritis | <input type="radio"/> YES <input type="radio"/> NO Alcohol Use | <input type="radio"/> YES <input type="radio"/> NO Chronic Pain |
| <input type="radio"/> YES <input type="radio"/> NO Breathing Disorder | <input type="radio"/> YES <input type="radio"/> NO HIV | <input type="radio"/> YES <input type="radio"/> NO Nasal Allergies |
| <input type="radio"/> YES <input type="radio"/> NO Congenital Heart Defects | <input type="radio"/> YES <input type="radio"/> NO Immune System Disorder | <input type="radio"/> YES <input type="radio"/> NO Meniere's Disease |
| <input type="radio"/> YES <input type="radio"/> NO Stroke | <input type="radio"/> YES <input type="radio"/> NO TMJ Disorder | <input type="radio"/> YES <input type="radio"/> NO Muscular Dystrophy |
| <input type="radio"/> YES <input type="radio"/> NO Heart Murmur | <input type="radio"/> YES <input type="radio"/> NO Coronary Disease | <input type="radio"/> YES <input type="radio"/> NO MS |
| <input type="radio"/> YES <input type="radio"/> NO Diabetes | <input type="radio"/> YES <input type="radio"/> NO Anxiety / Depression | <input type="radio"/> YES <input type="radio"/> NO Osteoporosis |
| <input type="radio"/> YES <input type="radio"/> NO Epilepsy | <input type="radio"/> YES <input type="radio"/> NO Difficulty Sleeping/ Insomnia | <input type="radio"/> YES <input type="radio"/> NO Parkinson's |
| <input type="radio"/> YES <input type="radio"/> NO High Blood Pressure | <input type="radio"/> YES <input type="radio"/> NO Fibromyalgia | <input type="radio"/> YES <input type="radio"/> NO Sleep Apnea |
| <input type="radio"/> YES <input type="radio"/> NO Low Blood Pressure | <input type="radio"/> YES <input type="radio"/> NO Excessive Daytime Sleepiness | <input type="radio"/> YES <input type="radio"/> NO Orthodontic Treatment |
| <input type="radio"/> YES <input type="radio"/> NO Tuberculosis | <input type="radio"/> YES <input type="radio"/> NO Glaucoma | <input type="radio"/> YES <input type="radio"/> NO Rheumatoid Arthritis |
| <input type="radio"/> YES <input type="radio"/> NO Psychiatric Treatment | <input type="radio"/> YES <input type="radio"/> NO Gout | <input type="radio"/> YES <input type="radio"/> NO Thyroid Disorder |
| <input type="radio"/> YES <input type="radio"/> NO Anemia | <input type="radio"/> YES <input type="radio"/> NO Hemophilia | <input type="radio"/> YES <input type="radio"/> NO Recurrent Ear Infections |
| <input type="radio"/> YES <input type="radio"/> NO Hepatitis | <input type="radio"/> YES <input type="radio"/> NO Cancer | <input type="radio"/> YES <input type="radio"/> NO Urinary Disorders |
| <input type="radio"/> YES <input type="radio"/> NO Sinus Trouble | | <input type="radio"/> YES <input type="radio"/> NO Tumors |
| <input type="radio"/> YES <input type="radio"/> NO Rheumatic Fever | | |

OTHER SYMPTOMS

- YES NO Teeth Grinding
- YES NO Teeth Clenching
- YES NO Dry Mouth
- YES NO Broken Teeth
- YES NO Ear Pain
- YES NO Ear Congestion
- YES NO Blurred Vision
- YES NO Eye Pain
- YES NO Chronic Sore Throat
- YES NO Feeling of Foreign Object in Throat
- YES NO Swelling in Neck
- YES NO Shoulder Pain
- YES NO Burning Tongue
- YES NO Snoring
- YES NO Tightness in Throat
- YES NO Joint Stiffness
- YES NO Headaches
- YES NO Skin Lesions
- YES NO Muscle Weakness or Paralysis
- YES NO Nail Malformations
- YES NO Fibromyalgia
- YES NO Numbness / Tingling in Hands or Fingers

REVIEW OF SYMPTOMS IN THE LAST 2 WEEKS

- YES NO Appetite Changes
- YES NO Marked Weight Changes
- YES NO Night Sweating
- YES NO Recent Trauma / Infection
- YES NO Tire Easily
- YES NO Ringing in Ears
- YES NO Sinus Infection
- YES NO Sore Throat / Hoarseness
- YES NO Swallowing Difficulty
- YES NO Ulcers or Lumps in Mouth
- YES NO Sore Gums or Tongue
- YES NO Neck Pain
- YES NO Neck Stiffness
- YES NO Persistent Cough
- YES NO Wheezing
- YES NO Shortness of Breath
- YES NO Swelling of Ankles
- YES NO Bruising Easily
- YES NO Arrhythmia
- YES NO Heart Burn
- YES NO Back Pain
- YES NO Muscle Cramps / Pain
- YES NO Dizziness
- YES NO Increased Thirst
- YES NO Heat Intolerance
- YES NO Cold Intolerance
- YES NO Increased Urination

1. Do you have any medical or dental problems? YES NO Explain: _____

2. Over the past two weeks, how often have you felt the following problems?
Not at All = 0, Several Days = 1, More than Half the Days = 2, Nearly Every Day = 3

Feeling nervous, anxious, or on edge _____ Not being able to stop or control worrying _____

Feeling down, depressed, or hopeless _____ Little pleasure or interest in doing things _____

3. Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in each situation?

0 = No Chance of Dozing, 1 = Slight Chance, 2 = Moderate Chance, 3 = High Chance

Sitting & reading _____ Watching TV _____ Sitting inactive in public (ie theater) _____

Passenger in a car (1 hr.+) _____ Lying down in the afternoon _____ Sitting and talking to someone _____

Sitting quietly after lunch _____ In a car, while stopped for a few minutes in traffic _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

YES NO Do you awake with headaches?

YES NO Has anyone seen you stop breathing in your sleep?

YES NO Do you snore?

YES NO Do you wake up refreshed?

YES NO Do you gasp at night?

YES NO How many times do you wake during sleep?

CHIEF COMPLAINT

Have you had a sleep study read by a physician? _____

If yes, in lab or at home? _____

Do you have Obstructive Sleep Apnea? *(Please send a copy of the study results)* _____

Mild, Moderate, Severe? _____

Have you tried CPAP, APAP, BIPAP? _____

Are you using it now? _____

If not why? _____

Do you have TMJ pain? *(If yes, we will request additional information to be filled out.)* _____

