Patient Information:

Comprehensive Health Questionnaire

☐ Mr. ☐ Ms. ☐ Miss. ☐ Mrs. ☐ Dr.

Full Name:

DOB:

Age:

Height: ft. in.

Weight: lbs.

Referred By:

☐ DDS. ☐ MD. ☐ DO. ☐ DC. ☐ Other. _____

Patient Address: City: State: Zip:

Phone #:

Alternate Phone #:

What are your reasons for this visit: _____

What are the results you are seeking from treatment: _____

Do you currently experience any of the following symptoms?

Number your top 5 symptoms 1 through 5

_____ Headache (inside your head)	☐ Recent	☐ Chronic		_____ Dizziness	☐ Recent	☐ Chronic	
_____ Headache (outside your head)	☐ Recent	☐ Chronic		_____ Ringing in Ears (Tinnitis)	☐ Recent	☐ Chronic	
_____ Jaw Pain	☐ Recent	☐ Chronic		_____ Vision Problems	☐ Recent	☐ Chronic	
_____ Chewing Pain	☐ Recent	☐ Chronic		_____ Muscle Spasm	☐ Recent	☐ Chronic	
_____ Face Pain	☐ Recent	☐ Chronic		_____ Sinus Congestion	☐ Recent	☐ Chronic	
_____ Eye Pain	☐ Recent	☐ Chronic		_____ Kicking or jerking leg repeatedly	☐ Recent	☐ Chronic	
_____ Throat Pain	☐ Recent	☐ Chronic		_____ Swelling in ankles or feet	☐ Recent	☐ Chronic	
_____ Neck Pain	☐ Recent	☐ Chronic		_____ Numbness (Localized)	☐ Recent	☐ Chronic	
_____ Shoulder Pain	☐ Recent	☐ Chronic		_____ Nerve Pain	☐ Recent	☐ Chronic	
_____ Back Pain	☐ Recent	☐ Chronic		_____ Dental Changes	☐ Recent	☐ Chronic	
_____ Dyskinesia	☐ Recent	☐ Chronic		_____ Teeth Spacing	☐ Recent	☐ Chronic	
_____ Difficulty Opening Mouth	☐ Recent	☐ Chronic		_____ Teeth Sensitivity	☐ Recent	☐ Chronic	
_____ Difficulty Closing Mouth	☐ Recent	☐ Chronic		_____ Changes with your Bite	☐ Recent	☐ Chronic	
_____ Noises in Jaw Joints	☐ Recent	☐ Chronic		_____ Morning Hoarseness	☐ Recent	☐ Chronic	
_____ Ear Stuffiness	☐ Recent	☐ Chronic		_____ Dry Mouth Upon Waking	☐ Recent	☐ Chronic	

Fatigue	Recent	Chronic		Significant Daytime Drowsiness	Recent	Chronic	
Difficulty Falling Asleep	Recent	Chronic		Affect Sleep of Others	Recent	Chronic	
Tossing and Turning Frequently	Recent	Chronic		Short of Breath when Waking	Recent	Chronic	
Repeated Awakening	Recent	Chronic		Told "I stop breathing" During Sleep	Recent	Chronic	
Feeling Un-refreshed in the Morning	Recent	Chronic		Night-Time Choking Spells	Recent	Chronic	
Morning Headaches	Recent	Chronic		Unable to Tolerate C-Pap	Recent	Chronic	
Nighttime Urination	Recent	Chronic		Tooth Grinding	Recent	Chronic	
Night Sweats	Recent	Chronic		Teeth Crowding	Recent	Chronic	
Vivid Dreams	Recent	Chronic		Frequent Heavy Snoring	Recent	Chronic	
Sore Jaw Upon Waking	Recent	Chronic		Acid Indigestion	Recent	Chronic	

Any Other Symptoms not listed above

Allergic Reactions

Please check any and all medications or substance that have caused an allergic reaction

- [ ] Anesthetics
- [ ] Antibiotics
- [ ] Aspirin
- [ ] Medication
- [ ] Barbiturates
- [ ] Codeine
- [ ] Iodine
- [ ] Latex
- [ ] Metals
- [ ] Plastics
- [ ] Penicillin
- [ ] Sedatives
- [ ] Sulfa
- [ ] Food Allergies/Sensitivities

Current Medications

Please list all medications and supplements (over-the-counter and prescription) you are taking and the reason you take them.

Medication	Dosage	Reason For Taking

- [ ] See Attached List

Previous Treatment, Medications and Other Therapies Attempted For The Condition We Are Evaluating

Treatment/Med/Therapy	Doctor/Provider	Approx. Date of Tx	Helpful (y/n)

- [ ] See Attached List

Sleep Conditions

Please select the yes or no answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Position? ☐ Side ☐ Back ☐ Stomach ☐ Varies

Sleep Location? ☐ Bed ☐ Couch ☐ Chair ☐ Other

Bed Partner? ☐ Yes ☐ No

Average hours of sleep per night? _____

Is it easy to fall asleep? ☐ Yes ☐ No

Average hours of sleep per day? _____

Do you wake often during the night? ☐ Yes ☐ No

Cough, gasps or snorts on waking? ☐ Yes ☐ No

Do you feel rested upon waking? ☐ Yes ☐ No

Observed pauses in breath? ☐ Yes ☐ No

Stopped breathing during sleep? ☐ Yes ☐ No

Have you ever had a sleep test?: ☐ HST ☐ PSG ☐ No Date: _____ Result: _____

Previous positive airway pressure devices used? ☐ CPAP ☐ BiPAP ☐ ASV ☐ APAP

Do you currently use a PAP Device? ☐ Yes ☐ No Type: _____

Previous Oral Appliance? ☐ Yes ☐ No Type: _____

Health And Medical History

Are you currently pregnant? ☐ Yes ☐ No

How many energy drinks do you drink? _____ /day

Do you drink 4 or more cups of coffee per day? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Yes ☐ No

Do you consume alcohol or take sedatives? ☐ Yes ☐ No

Do you have trouble breathing through your nose? ☐ Yes ☐ No

Have you had prior orthodontic treatments? ☐ Yes ☐ No

Have you had previous injury to: ☐ Head ☐ Neck ☐ Face ☐ Teeth ☐ Other

Surgical History

Have you had any of the following:

General Anesthesia	☐ Yes ☐ No	Orthognathic Surgery	☐ Yes ☐ No
Adenoids Removed	☐ Yes ☐ No	Oral Surgery	☐ Yes ☐ No
Tonsils Removed	☐ Yes ☐ No	Removal of Third Molar (Wisdom Teeth)	☐ Yes ☐ No
Jaw Joint Surgery	☐ Yes ☐ No		

Other surgeries: _____

Additional Health And Medical History

Do you have or have you experienced any of the following

Anemia	☐ Yes	☐ No	☐ Fam Hx	Fibromyalgia	☐ Yes	☐ No	☐ Fam Hx
Anxiety	☐ Yes	☐ No	☐ Fam Hx	Fluid Retention	☐ Yes	☐ No	☐ Fam Hx
Asthma	☐ Yes	☐ No	☐ Fam Hx	COPD	☐ Yes	☐ No	☐ Fam Hx
Bleeding Easily	☐ Yes	☐ No	☐ Fam Hx	Depression	☐ Yes	☐ No	☐ Fam Hx
Birth Defects	☐ Yes	☐ No	☐ Fam Hx	Diabetes	☐ Yes	☐ No	☐ Fam Hx
Bruising Easily	☐ Yes	☐ No	☐ Fam Hx	Difficulty Concentrating	☐ Yes	☐ No	☐ Fam Hx
Cancer of _____	☐ Yes	☐ No	☐ Fam Hx	Difficulty Breathing at Night	☐ Yes	☐ No	☐ Fam Hx
Chemo	☐ Yes	☐ No	☐ Fam Hx	Dizziness	☐ Yes	☐ No	☐ Fam Hx
Chronic Fatigue	☐ Yes	☐ No	☐ Fam Hx	Emphysema	☐ Yes	☐ No	☐ Fam Hx
Cold Hands and Feet	☐ Yes	☐ No	☐ Fam Hx	Epilepsy	☐ Yes	☐ No	☐ Fam Hx
				Excessive Thirst	☐ Yes	☐ No	☐ Fam Hx
				Fainting	☐ Yes	☐ No	☐ Fam Hx

Frequent Colds/Flu	☐ Yes	☐ No	☐ Fam Hx	Mitral Valve Prolaps	☐ Yes	☐ No	☐ Fam Hx
Frequent Cough	☐ Yes	☐ No	☐ Fam Hx	Multiple Sclerosis	☐ Yes	☐ No	☐ Fam Hx
Frequent Ear Infections	☐ Yes	☐ No	☐ Fam Hx	Muscle Aches	☐ Yes	☐ No	☐ Fam Hx
Frequent Sore Throat	☐ Yes	☐ No	☐ Fam Hx	Muscle Fatigue	☐ Yes	☐ No	☐ Fam Hx
Awakening from Sleep _____ x	☐ Yes	☐ No	☐ Fam Hx	Muscle Spasms	☐ Yes	☐ No	☐ Fam Hx
Gastroesophogeal Reflux	☐ Yes	☐ No	☐ Fam Hx	Muscular Dystrophy	☐ Yes	☐ No	☐ Fam Hx
Glaucoma	☐ Yes	☐ No	☐ Fam Hx	Neuralgia	☐ Yes	☐ No	☐ Fam Hx
Hay Fever	☐ Yes	☐ No	☐ Fam Hx	Nervous system Disorder	☐ Yes	☐ No	☐ Fam Hx
Hearing Impairment	☐ Yes	☐ No	☐ Fam Hx	Osteoarthritis	☐ Yes	☐ No	☐ Fam Hx
Heart Attack	☐ Yes	☐ No	☐ Fam Hx	Osteoporosis	☐ Yes	☐ No	☐ Fam Hx
Heart Disease	☐ Yes	☐ No	☐ Fam Hx	Ovarian Cyst	☐ Yes	☐ No	☐ Fam Hx
Heart Murmur	☐ Yes	☐ No	☐ Fam Hx	Parkinson's Disease	☐ Yes	☐ No	☐ Fam Hx
Heart Pacemaker	☐ Yes	☐ No	☐ Fam Hx	Poor Circulation	☐ Yes	☐ No	☐ Fam Hx
Heart Palpitations	☐ Yes	☐ No	☐ Fam Hx	Psychiatric Care	☐ Yes	☐ No	☐ Fam Hx
Heart Valve Replacement	☐ Yes	☐ No	☐ Fam Hx	Radiation	☐ Yes	☐ No	☐ Fam Hx
Hemophilia	☐ Yes	☐ No	☐ Fam Hx	Recent Weight Gain	☐ Yes	☐ No	☐ Fam Hx
Hepatitis	☐ Yes	☐ No	☐ Fam Hx	Recent Weight Loss	☐ Yes	☐ No	☐ Fam Hx
High Blood Pressure	☐ Yes	☐ No	☐ Fam Hx	Rheumatic Fever	☐ Yes	☐ No	☐ Fam Hx
History of Substance Abuse	☐ Yes	☐ No	☐ Fam Hx	Rheumatoid Arthritis	☐ Yes	☐ No	☐ Fam Hx
Huntington's Disease	☐ Yes	☐ No	☐ Fam Hx	Scarlet Fever	☐ Yes	☐ No	☐ Fam Hx
Hypoglycemia	☐ Yes	☐ No	☐ Fam Hx	Shortness of Breath	☐ Yes	☐ No	☐ Fam Hx
Insomnia	☐ Yes	☐ No	☐ Fam Hx	Skin Disorder	☐ Yes	☐ No	☐ Fam Hx
Intestinal Disorder	☐ Yes	☐ No	☐ Fam Hx	Sinus Problems	☐ Yes	☐ No	☐ Fam Hx
Irregular Heartbeat	☐ Yes	☐ No	☐ Fam Hx	Slow Healing Sores	☐ Yes	☐ No	☐ Fam Hx
Kidney Disease	☐ Yes	☐ No	☐ Fam Hx	Speech Difficulties	☐ Yes	☐ No	☐ Fam Hx
Leukemia	☐ Yes	☐ No	☐ Fam Hx	Stroke	☐ Yes	☐ No	☐ Fam Hx
Liver Disease	☐ Yes	☐ No	☐ Fam Hx	Swollen or Painful Joints	☐ Yes	☐ No	☐ Fam Hx
Low Blood Pressure	☐ Yes	☐ No	☐ Fam Hx	Thyroid Disease	☐ Yes	☐ No	☐ Fam Hx
Meniere's Disease	☐ Yes	☐ No	☐ Fam Hx	Tired Muscles	☐ Yes	☐ No	☐ Fam Hx
Memory Loss	☐ Yes	☐ No	☐ Fam Hx	Tuberculosis	☐ Yes	☐ No	☐ Fam Hx
Migraines	☐ Yes	☐ No	☐ Fam Hx	Urinary Tract Disorder	☐ Yes	☐ No	☐ Fam Hx

History of Symptoms

On what date, or approximate date, did the condition you are seeking treatment for occur? _____

Are the conditions listed as the reason for visit caused by a motor vehicle accident? ☐ Yes ☐ No

If yes, what conditions: _____ Date of accident: _____

Does any family member snore or have sleep apnea? ☐ Yes ☐ No If yes, explain: _____

Additional Symptoms

Head Pain

	Location (L = Left R = Right B = Bilateral)					Severity Mild, Mod, Severe			Duration Hours, Days, Weeks			Frequency Occ, Freq, Constant		
Temple Area	☐ L	☐ R	☐ B	☐ Recent	☐ Chronic	☐ M	☐ Mo	☐ S	☐ H	☐ D	☐ W	☐ O	☐ F	☐ C
Back of Head	☐ L	☐ R	☐ B	☐ Recent	☐ Chronic	☐ M	☐ Mo	☐ S	☐ H	☐ D	☐ W	☐ O	☐ F	☐ C
Forehead	☐ L	☐ R	☐ B	☐ Recent	☐ Chronic	☐ M	☐ Mo	☐ S	☐ H	☐ D	☐ W	☐ O	☐ F	☐ C
Top of Head	☐ L	☐ R	☐ B	☐ Recent	☐ Chronic	☐ M	☐ Mo	☐ S	☐ H	☐ D	☐ W	☐ O	☐ F	☐ C
All of Head	☐ L	☐ R	☐ B	☐ Recent	☐ Chronic	☐ M	☐ Mo	☐ S	☐ H	☐ D	☐ W	☐ O	☐ F	☐ C

Jaw Pain

Jaw pain with opening ☐ L ☐ R

Jaw pain when chewing ☐ L ☐ R

Jaw pain at rest ☐ L ☐ R

Jaw Joint Sounds

Jaw sounds with opening ☐ L ☐ R

Jaw sounds when chewing ☐ L ☐ R

Jaw Locking

Jaw locks closed ☐ Yes ☐ No

Jaw locks open ☐ Yes ☐ No

Jaw Joint Symptoms

Teeth clenching ☐ Yes ☐ No ☐ Day ☐ Night

Teeth grinding ☐ Yes ☐ No ☐ Day ☐ Night

Eye Related Conditions

Blurred vision ☐ Yes ☐ No

Double vision ☐ Yes ☐ No

Eye pain ☐ Yes ☐ No

Pain or pressure behind the eyes ☐ Yes ☐ No

Extreme sensitivity to light ☐ Yes ☐ No

Wear of glasses or contacts ☐ Yes ☐ No

Ear Related Conditions

Buzzing in ears ☐ L ☐ R

Ear Congestion ☐ L ☐ R

Ear pain ☐ L ☐ R

Hearing Loss ☐ L ☐ R

Itchiness/stuffiness ☐ L ☐ R

Pain behind the ear ☐ L ☐ R

Pain in front of ear ☐ L ☐ R

Recurrent ear infections ☐ L ☐ R

Ringing in the ear (tinnitus) ☐ L ☐ R

Throat Related Conditions

Chronic sore throat ☐ Yes ☐ No

Difficulty Swallowing ☐ Yes ☐ No

Swollen glands ☐ Yes ☐ No

Thyroid enlargement ☐ Yes ☐ No

Tightness in throat ☐ Yes ☐ No

Feeling of foreign object in throat ☐ Yes ☐ No

Neck related Conditions

Limited movement ☐ Yes ☐ No

Neck pain ☐ Yes ☐ No

Numbness in hands/fingers ☐ Yes ☐ No

Swelling in neck ☐ Yes ☐ No

Shoulder Conditions

Pain in Shoulder ☐ Yes ☐ No

Stiffness in Shoulder ☐ Yes ☐ No

Tingling in fingers/hands ☐ Yes ☐ No

Back Conditions

Low Back Pain ☐ Yes ☐ No

Middle Back Pain ☐ Yes ☐ No

Upper Back Pain ☐ Yes ☐ No

Scoliosis ☐ Yes ☐ No

Sciatica ☐ Yes ☐ No

Mouth/Nose Conditions

Chronis Sinusitis ☐ Yes ☐ No

Dry Mouth ☐ Yes ☐ No

Frequent Snoring ☐ Yes ☐ No

Broken Teeth ☐ Yes ☐ No

Biting Cheeks ☐ Yes ☐ No

Burning Tongue ☐ Yes ☐ No

Even if your symptoms are pain related please - Complete this section

1. Daytime Sleepiness Evlauation - Epworth Sleepiness Scale

For the following situations, answer with one of the following numbers:
0 - would never doze 1 - slight chance of dozing 2 - moderate chance of dozing 3 - high chance of dozing

Situation	Score	Situation	
Sitting and reading		Sitting and talking to someone	
Watching Television		Sitting quietly after a lunch (no alcohol)	
Sitting, inactive public place		In a car, while stopped for a few minutes in traffic	
As a passenger in a car for an hour without a break		Lying down to rest in the afternoon when circumstances permit	

2. Nighttime Sleepiness Evaluation

Add Your Score _____

Developed by David White, M.D., Harvard Medical School, Boston, MA

Score

1. Snoring

a) Do you snore on most nights (>3 nights per week)?

Yes (2) No (0)

b) Is your snoring loud? Can it be heard through a door or wall?

Yes (2) No (0)

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0) Occasionally (3) Frequently (5)

3. What is your collar size?

Male: Less than 17 inches (0) More than 17 inches (5)

Female: Less than 16 inches (0) More than 16 inches (5)

4. Do you occasionally fall asleep during the day when:

a) You are busy or active

Yes (2) No (0)

b) You are driving or stopped at a light?

Yes (2) No (0)

5. Have you had or are you being treated for high blood pressure?

Yes (2) No (0)

Add Lines 1 -5 _____

Patient/ Guardian Signature: _____ Date: _____

(This signature represents my completing pages 1-6)