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Comprehensive Health Questionnaire

Patient Information:

☐ 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 is your chief concern and reason for this visit: ____________________

What are the results you are seeking from treatment: ____________________

Do you currently experience any of the following symptoms?

Please number your top chief complaints 1-5

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

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Symptom	Recent	Chronic	Symptom	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
- ☐ 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

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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
Is it easy to fall asleep?	☐ Yes	☐ No
Do you wake often during the night?	☐ Yes	☐ No
Do you feel rested upon waking?	☐ Yes	☐ No
Stopped breathing during sleep?	☐ Yes	☐ No

Average hours of sleep per night? ______

Average hours of sleep per day? ______

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

Observed pauses in breath? ☐ Yes ☐ No

Have you ever sustained injury to: ☐ 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
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
Adenoids Removed	☐ Yes	☐ No
Tonsils Removed	☐ Yes	☐ No
Jaw Joint Surgery	☐ Yes	☐ No
Orthognathic Surgery	☐ Yes	☐ No
Oral Surgery	☐ Yes	☐ No
Removal of Third Molar (Wisdom Teeth)	☐ Yes	☐ No

Other types of surgery: ______

Additional Health And Medical History

Do you have or have you experienced any of the following

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

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Condition	Yes	No	Fam Hx	Condition	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 any of the conditions listed or was your chief complaint caused by a motor vehicle accident? ☐ Yes ☐ No

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

Does any family member have a sleep breathing disorder? ☐ Yes ☐ No If yes, explain: ____________________

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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 Sound

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

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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	______

Total Score ______

2. Nighttime Sleepiness Evaluation

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)

Total ______

Patient/ Guardian Signature: ______________________ Date: ______________

(This signature represents my completing pages 1-6)