



**ALLERGIC REACTIONS**

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

- |                                      |                                  |                                     |
|--------------------------------------|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Iodine  | <input type="checkbox"/> Plastic    |
| <input type="checkbox"/> Aspirin     | <input type="checkbox"/> Latex   | <input type="checkbox"/> Sedatives  |
| <input type="checkbox"/> Barbituates | <input type="checkbox"/> Metals  | <input type="checkbox"/> Sulfa      |

**Other:** \_\_\_\_\_

**CURRENT MEDICATIONS**

*Please list all medications you are taking and the reason you take them. Include all over-the-counter medications, vitamins, herbs, etc.*

Medication	Dosage	Reason for Taking

**PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING**

Treatment and/or Medication	Doctor/Provider Name	Approximate Date of Treatment

I release and give my permission for this office to request information and communicate with the providers listed above.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent/Guardian Signature (if patient is a minor): \_\_\_\_\_ Date: \_\_\_\_\_

**HEALTH AND MEDICAL HISTORY**

- |                              |                             |  |                               |                               |                                   |                                |                                       |
|------------------------------|-----------------------------|--|-------------------------------|-------------------------------|-----------------------------------|--------------------------------|---------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you currently pregnant?                    | <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Face     | <input type="checkbox"/> Teeth | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you sustained injury to:                  |                               |                               |                                   |                                |                                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you drink 4 or more cups of coffee per day? | <input type="checkbox"/> Yes  | <input type="checkbox"/> No   | Do you smoke tobacco?             |                                |                                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you had prior orthodontic treatments?     | <input type="checkbox"/> Yes  | <input type="checkbox"/> No   | Consume alcohol or take sedatives |                                |                                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Trouble breathing through nose                 |                               |                               |                                   |                                |                                       |

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HEALTH AND MEDICAL HISTORY (CONTINUED)**

*Do you have, or have you experienced any of the following:*

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disorder/ Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problem
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve prolaps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Intestinal Disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous System Disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anxiety
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Valve Replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Urinary Tract Disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic Fatigue
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fibromyalgia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cold hands and feet
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bruising Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer of	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty concentrating
		Chemo <input type="checkbox"/> Radiation <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty breathing at night for sleep
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dizziness
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Excessive Thirst
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Birth Defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fluid Retention
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent colds/flu
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent cough
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent ear infections
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gastroesophgeal Reflex (Gerd)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent sore throat
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent awaking at night - number of times _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing impairment
<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of Substance Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Memory Loss
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hay Fever
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Huntington's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Insomnia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle aches
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle fatigue
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle spasms
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle tremors
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Meniere's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Poor circulation
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscular Dystrophy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent weight gain
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neuralgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent weight loss
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoarthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of breath
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Overian Cyst	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Slow healing sores
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Speech difficulties
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rhumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen, stiff or painful joints
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tired muscles
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever			

Additional Information \_\_\_\_\_

**SURGICAL HISTORY** *Have you had any of the following:*

<input type="checkbox"/> Yes	<input type="checkbox"/> No	General Anesthesia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Orthognathic Surgery
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Adnoids removed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Oral Surgery
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsils removed			Removal of third molar (wisdom teeth) <input type="checkbox"/> Other <input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw Joint Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other surgery _____

*please list below*

Other types of surgery \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CURRENT SYMPTOMS**

**Head Pain**

Location			Recent	Chronic (over 6 mo.)	Severity			Duration			Frequency		
L	R	B			Mild	Mod	Severe	Min.	Hrs.	Days	Occasional	Frequent	Constant
L=Left R=Right B=Bilateral													
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Do you have pain or discomfort in any of the following areas? If so, please indicate the approximate date the pain began.*

**Jaw Pain**

L  R Jaw pain with opening  
 L  R Jaw pain when chewing  
 L  R Jaw pain at rest

**Jaw Joint Sounds**

L  R Jaw sounds with opening  
 L  R Jaw sounds when chewing  
 L  R Jaw sounds at rest

**Jaw Locking**

Yes  No Jaw locks closed  
 Yes  No Jaw locks open

**Jaw Joint Symptoms**

Yes  No Teeth clenching  Day  Night  
 Yes  No Teeth grinding  Day  Night

**Eye Related Conditions**

Yes  No Blurred vision  
 Yes  No Double vision  
 Yes  No Eye pain

Yes  No Pain or pressure behind the eyes  
 Yes  No Extreme sensitivity to light (photophobia)  
 Yes  No Wear of glasses or contact lenses

**Ear Related Conditions**

L  R Buzzing in the ears  
 L  R Ear congestion  
 L  R Ear pain  
 L  R Hearing loss  
 L  R Itchiness or Stiffness in ears

L  R Pain behind the ear  
 L  R Pain in front of the ear  
 L  R Recurrent ear infections  
 L  R Ringing in the ear (Tinnitus)

**Throat Related Conditions**

Yes  No Chronic sore throat  
 Yes  No Difficulty swallowing  
 Yes  No Swollen glands

Yes  No Thyroid enlargement  
 Yes  No Tightness in throat  
 Yes  No Constant feeling of a foreign object in throat

**Neck Related Conditions**

Yes  No Limited movement of neck  
 Yes  No Neck pain

Yes  No Numbness in hands or fingers  
 Yes  No Swelling in the neck

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Shoulder Related Conditions**

Yes  No Shoulder pain  
 Yes  No Shoulder stiffness

Yes  No Tingling in hands or fingers

**Back Related Conditions**

Yes  No Back pain - lower  
 Yes  No Back pain - middle  
 Yes  No Back pain - upper

Yes  No Sciatica  
 Yes  No Scoliosis

**Mouth and Nose Related Conditions**

Yes  No Dry mouth  
 Yes  No Chronic sinusitis  
 Yes  No Frequent snoring

Yes  No Burning tongue  
 Yes  No Broken teeth  
 Yes  No Frequent biting of the cheek

**Sleep Conditions**

Sleep Positions  Side  Back  Stomach

Is it easy to fall asleep? \_\_\_\_\_

Do you feel rested upon AM waking? \_\_\_\_\_

Stopped breathing during sleep? \_\_\_\_\_

Average hours of sleep per night? \_\_\_\_\_

Do you wake often during the night? \_\_\_\_\_

Gasping or Choking during sleep? \_\_\_\_\_

Have you ever had a Sleep Study (PSG)? \_\_\_\_\_

**HISTORY OF SYMPTOMS**

**On what date, or approximate date, did this condition or symptoms first occur?**

Yes  No **Does any family member have the same or similar problem? If yes, please explain.**

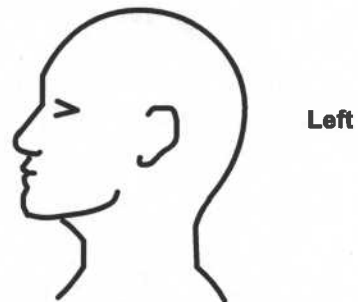
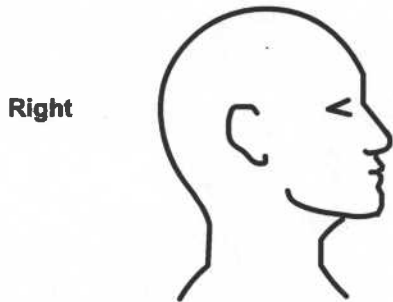
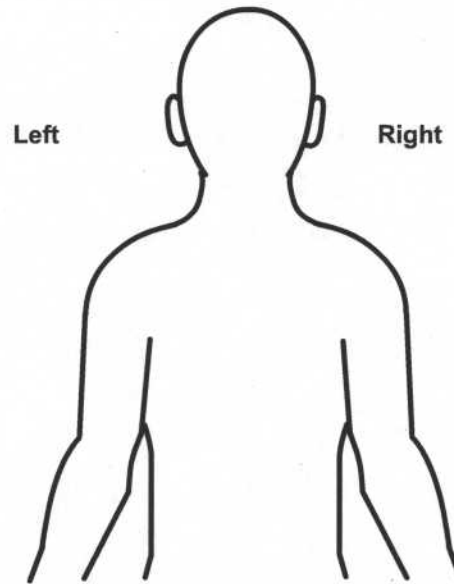
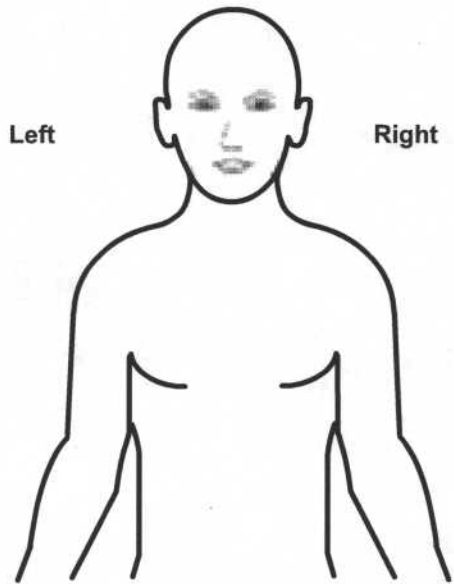
**Can you relate your pain or condition to a motor vehicle accident or traumatic injury?**

**If yes, please complete Trauma History Section, enclosed as a separate form.**

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if patient is a minor): \_\_\_\_\_ Date: \_\_\_\_\_



**Indicate Areas of Pain**  
**Following the Pain Scale:**  
**1 Mild pain**  
**2 Moderate pain**  
**3 Severe pain**

# Daytime Sleepiness Evaluation

## Epworth Sleepiness Scale

The Epworth Sleepiness Scale was developed and validated by Dr. Murray Johns of Melbourne Australia. It is a simple, self-administered questionnaire –widely used by sleep professionals in quantifying the level of daytime sleepiness.

***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***

<b>Situation</b>	<b>Score</b>
Sitting and reading	
Watching Television	
Sitting, inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
<b>Total Score</b>	

# Nighttime Sleepiness Evaluation

## Screening Tool for Sleep Apnea

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

Please answer the following questions.

### 1. Snoring

a) Do you snore on most night (> 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 (1)

No (0)

\_\_\_\_\_

**TOTAL**

\_\_\_\_\_

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Score

**9 points or more**

Refer to sleep specialist or order sleep study

**6-8 points**

Gray area, use clinical judgment

**5 points or less**

Low probability of sleep apnea

**AUTHORIZATION TO RELEASE INFORMATION TO THE BELOW  
LISTED REFERRING AND TREATING HEALTH CARE  
PROFESSIONALS:**

**Doctors Name**

**Location/Phone**

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I authorize the release of communications regarding my treatment with \_\_\_\_\_ including a full report of examination findings, diagnosis, treatment plan, and progress reports to the providers listed above.

Signed \_\_\_\_\_ Date \_\_\_\_\_