STOP

PLEASE READ ALL OF THE INSTRUCTIONS CAREFULLY BEFORE FILLING OUT THE FORM

- Do not fill out the form from a mobile phone or device
- Please make sure you download the form and fill it out through Adobe Acrobat Reader (Do not submit through your internet browser)
- Make sure you scroll all the way to the bottom of the form when finished and click the "Submit" button
- Upon submission, please wait 30 seconds to ensure the form has been fully processed

Comprehensive Health Questionnaire

Demographic Information

☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr.

First Name:_____Middle Initial:_____ Last Name:_____

Age: _____ Date of Birth:_____ Height: _____ Weight: _____

Ethnicity: ☐Native American/Alaska Native ☐Asian ☐African American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other ☐Decline to Answer

Responsible Party/Legal Guardian (if different than patient): _____ Relationship: _____

Contact Information

Address:_____ Address 2: _____

City: _____ State: _____ Zip: _____

Email: _____ Home/Cell: _____

Employer: _____ Work Phone: _____

Referred by: _____ ☐ Dentist ☐ Physician ☐ Patient ☐ Other

Provider Information

Dental Provider Office: _____ Last Visit: _____

Dentist Name: _____ Office Phone: _____

City: _____State:_____ Zip: _____

Primary Care Physician Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____State:_____ Zip: _____

Additional Provider Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone:_____

City: _____ State:_____ Zip: _____

Patient/Parent Signature: _____ Date: _____

Please answer below for: What is your chief concern and reason for this visit?

_____

_____

Do you currently experience any of the following symptoms?

Please number your top chief complaints 1-4

Recent is in the last 6 months, Chronic is longer than 6 months

	Recent	Chronic
____ Back Pain	☐	☐
____ Chewing Pain	☐	☐
____ Ear Pain	☐	☐
____ Eye Pain	☐	☐
____ Facial Pain	☐	☐
____ Headache (inside head)	☐	☐
____ Headache (outside head)	☐	☐
____ Jaw Pain	☐	☐
____ Neck Pain	☐	☐
____ Nerve Pain	☐	☐
____ Shoulder Pain	☐	☐
____ Tooth Pain	☐	☐
____ Throat Pain	☐	☐
____ Difficulty Closing Mouth	☐	☐
____ Difficulty Opening Mouth	☐	☐
____ Dizziness	☐	☐
____ Dyskinesia	☐	☐
____ Ear Stuffiness (congestion)	☐	☐
____ Ear Itching	☐	☐
____ Jaw Locking Open	☐	☐
____ Jaw Locking Closed	☐	☐
____ Muscle Spasm	☐	☐
____ Noises in Jaw Joints	☐	☐
____ Numbness (Localized)	☐	☐
____ Ringing in Ears (Tinnitus)	☐	☐
____ Sinus Congestion	☐	☐
____ Vision Problems	☐	☐
____ Changes in Bite	☐	☐
____ Dental Pain	☐	☐
____ Teeth Crowding or Spacing issues	☐	☐

	Recent	Chronic
____ Teeth Sensitivity	☐	☐
____ Acid Indigestion	☐	☐
____ Affect Sleep of Others	☐	☐
____ Difficulty Falling Asleep	☐	☐
____ Dry Mouth Upon Waking	☐	☐
____ Fatigue	☐	☐
____ Feeling Un-refreshed in the AM	☐	☐
____ Frequent Heavy Snoring	☐	☐
____ Morning Headaches	☐	☐
____ Morning Hoarseness	☐	☐
____ Night Sweats	☐	☐
____ Nighttime Awakenings	☐	☐
____ Nighttime Choking	☐	☐
____ Nighttime Urination	☐	☐
____ Shortness of Breath	☐	☐
____ Significant Daytime Drowsiness	☐	☐
____ Sore Jaw Upon Waking	☐	☐
____ Swelling in Ankles or Feet	☐	☐
____ Told I Stop Breathing at Sleep	☐	☐
____ Teeth Grinding	☐	☐
____ Teeth Clenching	☐	☐
____ Tossing and Turning Frequently	☐	☐
____ Unable to Tolerate C-Pap	☐	☐
____ Vivid Dreams	☐	☐
____ Jaw/Facial Fatigue upon waking	☐	☐
____ Kicking or jerking of leg(s)	☐	☐
____ Any other symptoms not listed: _____		

_____

What is your level of head, neck or facial pain: 0 = no pain to 10 = worst possible pain

Currently: _____ At its best: _____ At its worst: _____

What are the results you are seeking from treatment?

_____

_____

Patient/Parent Signature: _____Date: _____

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 you sleep during the night? _____

Is it easy to fall asleep? ☐**Yes** ☐**No** How many hours do you sleep during the 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 Study? ☐Yes ☐No ☐HST ☐PSG Date: _____ Result: _____

Previous Positive Airway Pressure Devices Used? ☐CPAP ☐BiPAP ☐ASV ☐APAP

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

Have you previously used a Nighttime Oral Appliance? ☐Yes ☐No Type: _____

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 _____

Other: _____

Current Medications

Please list all medications & supplements *(over-the-counter & prescription) you are taking and the reason you take them* ***OR Provide a copy of your personal Medication List***

Medication	Dose	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ **See attached list**

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

Treatment/Medication	Doctor/Provider	Approximate Date of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ See attached

Health And Medical History

FOR FEMALE PATIENTS: 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 for pain relief or sleeping aid? ☐Yes ☐No

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

Have you had prior orthodontic treatments? ☐Yes ☐No

Have you sustained injury to: ☐Head ☐Neck ☐Face ☐Teeth

☐Other: _____ Approximate Date:_____

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(s)	☐ Yes	☐No
Jaw Joint Surgery	☐ Yes	☐No	(Wisdom Teeth)		

Other types of surgery:_____

Patient/Parent Signature: _____ Date: _____

Medical History – Patient and Family

Do you have or have experienced any of the following?

	PATIENT HX	FAMILY HX
AIDS/HIV	☐ Yes ☐ No	
Anemia	☐ Yes ☐ No	☐ Fam Hx
Anxiety	☐ Yes ☐ No	☐ Fam Hx
Asthma	☐ Yes ☐ No	☐ Fam Hx
Awakenings from Sleep x	☐ 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
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
Eating Disorder	☐ Yes ☐ No	☐ Fam Hx
(EDS) Ehlers-Danlos Syndrome	☐ 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
Fibromyalgia	☐ Yes ☐ No	☐ Fam Hx
Fluid Retention	☐ Yes ☐ No	☐ Fam Hx
Frequent Colds/Flu	☐ Yes ☐ No	☐ Fam Hx
Frequent Cough	☐ Yes ☐ No	☐ Fam Hx
Frequent Ear Infections	☐ Yes ☐ No	☐ Fam Hx
Frequent Sore Throat	☐ Yes ☐ No	☐ Fam Hx
Gastroesophogeal Reflux	☐ Yes ☐ No	☐ Fam Hx
Glaucoma	☐ Yes ☐ No	☐ Fam Hx
Hay Fever	☐ Yes ☐ No	☐ Fam Hx
Hearing Impairment	☐ Yes ☐ No	☐ Fam Hx
Heart Attack	☐ Yes ☐ No	☐ Fam Hx
Heart Disease	☐ Yes ☐ No	☐ Fam Hx
Heart Murmur	☐ Yes ☐ No	☐ Fam Hx
Heart Pacemaker	☐ Yes ☐ No	☐ Fam Hx
Heart Palpitations	☐ Yes ☐ No	☐ Fam Hx
Heart Valve Replacement	☐ Yes ☐ No	☐ Fam Hx
Hemophilia	☐ Yes ☐ No	☐ Fam Hx
Hepatitis	☐ Yes ☐ No	☐ Fam Hx
High Blood Pressure	☐ Yes ☐ No	☐ Fam Hx
History of Substance Abuse	☐ Yes ☐ No	☐ Fam Hx
Huntington's Disease	☐ Yes ☐ No	☐ Fam Hx

☐ **I HAVE NO FAMILY HX**

	PATIENT HX	FAMILY HX
Hypoglycemia	☐ Yes ☐ No	☐ Fam Hx
Insomnia	☐ Yes ☐ No	☐ Fam Hx
Intestinal Disorder	☐ Yes ☐ No	☐ Fam Hx
Irregular Heartbeat	☐ Yes ☐ No	☐ Fam Hx
Kidney Disease	☐ Yes ☐ No	☐ Fam Hx
Leukemia	☐ Yes ☐ No	☐ Fam Hx
Liver Disease	☐ Yes ☐ No	☐ Fam Hx
Low Blood Pressure	☐ Yes ☐ No	☐ Fam Hx
Meniere's Disease	☐ Yes ☐ No	☐ Fam Hx
Memory Loss	☐ Yes ☐ No	☐ Fam Hx
Migraines	☐ Yes ☐ No	☐ Fam Hx
Mitral Valve Prolapse	☐ Yes ☐ No	☐ Fam Hx
Multiple Sclerosis	☐ Yes ☐ No	☐ Fam Hx
Muscle Aches	☐ Yes ☐ No	☐ Fam Hx
Muscle Fatigue	☐ Yes ☐ No	☐ Fam Hx
Muscle Spasms	☐ Yes ☐ No	☐ Fam Hx
Muscular Dystrophy	☐ Yes ☐ No	☐ Fam Hx
Neuralgia	☐ Yes ☐ No	☐ Fam Hx
Nervous system Disorder	☐ Yes ☐ No	☐ Fam Hx
Osteoarthritis	☐ Yes ☐ No	☐ Fam Hx
Osteoporosis	☐ Yes ☐ No	☐ Fam Hx
Ovarian Cyst	☐ Yes ☐ No	☐ Fam Hx
Parkinson's Disease	☐ Yes ☐ No	☐ Fam Hx
Poor Circulation	☐ Yes ☐ No	☐ Fam Hx
(POTS) Postural Orthostatic Tachycardia Syndrome	☐ Yes ☐ No	☐ Fam Hx
Psychiatric Care	☐ Yes ☐ No	☐ Fam Hx
Radiation	☐ Yes ☐ No	☐ Fam Hx
Recent Weight Gain	☐ Yes ☐ No	☐ Fam Hx
Recent Weight Loss	☐ Yes ☐ No	☐ Fam Hx
Rheumatic Fever	☐ Yes ☐ No	☐ Fam Hx
Rheumatoid Arthritis	☐ Yes ☐ No	☐ Fam Hx
Scarlet Fever	☐ Yes ☐ No	☐ Fam Hx
Shortness of Breath	☐ Yes ☐ No	☐ Fam Hx
Skin Disorder	☐ Yes ☐ No	☐ Fam Hx
Sinus Problems	☐ Yes ☐ No	☐ Fam Hx
Slow Healing Sores	☐ Yes ☐ No	☐ Fam Hx
Speech Difficulties	☐ Yes ☐ No	☐ Fam Hx
Stroke	☐ Yes ☐ No	☐ Fam Hx
Swollen or Painful Joints	☐ Yes ☐ No	☐ Fam Hx
Thyroid Disease	☐ Yes ☐ No	☐ Fam Hx
Tired Muscles	☐ Yes ☐ No	☐ Fam Hx
Tuberculosis	☐ Yes ☐ No	☐ Fam Hx
Urinary Tract Disorder	☐ Yes ☐ No	☐ Fam Hx

OTHER _____

Patient/Parent Signature: _____ Date:_____

Additional Symptoms – HEAD PAIN **Please complete for all that apply:**

1. **Do you experience General Head Pain?** ☐Yes ☐No

		Location (L = Left R = Right B = Bilateral)	Recent/Chronic (over 6mo.)	Severity	Duration	Frequency
				Mild Mod Severe	Hrs Days Wks	Occ. Freq Constant
2.	Temple Area	☐L ☐R ☐B	☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
3.	Back of Head	☐L ☐R ☐B	☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
4.	Forehead	☐L ☐R ☐B	☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
5.	Top of Head	☐L ☐R ☐B	☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐

For the below categories, please indicate L or R where applicable

Jaw Pain ☐ I have no jaw pain

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

Jaw Joint Sounds ☐ I have no jaw joint sounds

Jaw sounds with opening	☐L	☐R
Jaw sounds when chewing	☐L	☐R

Ear Related Conditions

Buzzing in ears	☐L	☐R	Pain behind the ear	☐L	☐R
Ear Congestion	☐L	☐R	Pain in front of ear	☐L	☐R
Ear pain	☐L	☐R	Recurrent ear infections	☐L	☐R
Hearing Loss	☐L	☐R	Ringing in the ear (tinnitus)	☐L	☐R
Itchiness/stuffiness	☐L	☐R			

For the below categories, please respond with Yes or No .... *DO NOT LEAVE BLANK*

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	Pain or pressure behind the eyes	☐Yes	☐No
Double vision	☐Yes	☐No	Extreme sensitivity to light	☐Yes	☐No
Eye pain	☐Yes	☐No	Wear of glasses or contacts	☐Yes	☐No

Throat Related Conditions

Chronic sore throat	☐Yes	☐No	Thyroid enlargement	☐Yes	☐No
Difficulty Swallowing	☐Yes	☐No	Tightness in throat	☐Yes	☐No
Swollen glands	☐Yes	☐No	Feeling of foreign object in throat	☐Yes	☐No

Neck related Conditions

Limited movement	☐Yes	☐No	Numbness in hands/fingers	☐Yes	☐No
Neck pain	☐Yes	☐No	Swelling in neck	☐Yes	☐No

Shoulder Conditions

Pain in Shoulders	☐Yes	☐No	Tingling in fingers/hands	☐Yes	☐No
Stiffness in Shoulders	☐Yes	☐No			

Back Conditions

Low Back Pain	☐Yes	☐No	Scoliosis	☐Yes	☐No
Middle Back Pain	☐Yes	☐No	Sciatica	☐Yes	☐No
Upper Back Pain	☐Yes	☐No			

Mouth/Nose Conditions

Chronic Sinusitis	☐Yes	☐No	Broken Teeth	☐Yes	☐No
Dry Mouth	☐Yes	☐No	Biting Cheeks	☐Yes	☐No
Frequent Snoring	☐Yes	☐No	Burning Tongue	☐Yes	☐No

Patient/Parent Signature: _____ Date: _____

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: _____

_____

Please fully complete both sections 1. and 2. below

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	Score
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

1. Snoring — Score

   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) _____

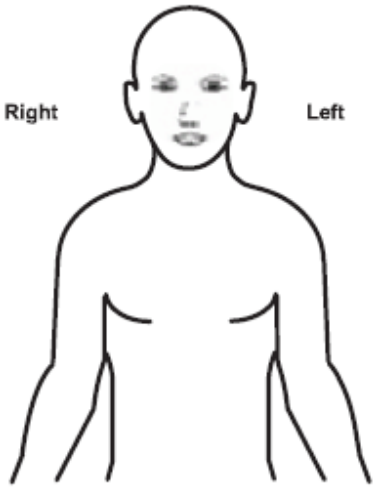
5. Have you had or are you being treated for high blood pressure?

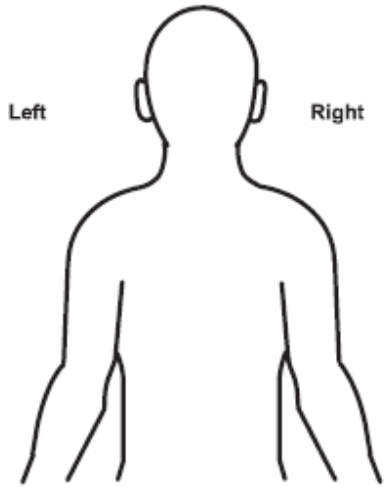
   Yes (2) No (0) _____

TOTAL _____

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, third party billing companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance covers.

Patient/Parent Signature: _____ Date: _____





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

Submit