North County Cosmetic and Implant Dentistry

www.ultimatesmiles.com info@ultimatesmiles.com
1934 Via Centre | Suite A • Vista, CA 92081 (760)940-2273

SleepApnea Medical History

In an effort to access your medical benefits and gain the maximum reimbursement for you, we need your assessment and details of your physical and mental health. This information will be used to gain the proper authorization for your procedures. Please be detailed in your responses.

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Do you have a recent sleep study report? Name and phone number of Primary Care Physician: *

_____

Have you ever had surgery or been hospitalized? * ◯ Yes ◯ No

If yes, please explain:

_____

List any medications you are currently taking:

_____

Are you allergic to any medications? * ◯ Yes ◯ No

If yes, please list:

_____

Do you smoke or use tobacco? * ◯ Yes ◯ No

Have you experienced shortness of breath? * ◯ Yes ◯ No

Do you use alcohol? * ◯ Yes ◯ No

If yes, how many drinks per week? _____

Have you lost or gained more than 10 lbs. in the past year? * ◯ Yes ◯ No

Do you have a latex allergy? * ◯ Yes ◯ No

Do you snore? * ◯ Yes ◯ No

Are you CPAP intolerant? * ◯ Yes ◯ No

Other: Please list

For Women Only

Are you currently taking Birth Control Pills? ◯ Yes ◯ No

Are you nursing? ◯ Yes ◯ No

Are you pregnant? ◯ Yes ◯ No

Do you have or had any of the following?

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Artificial HeartValve Replacement
- ☐ Asthma
- ☐ Autoimmune disrders
- ☐ Bleeding Disorders
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Chronic Fatigue
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Difficulty Concentrating
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilesy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting or Dizzy Spells
- ☐ Fibromyalgia
- ☐ General Allergies/Hay Fever
- ☐ (GERD) Gastroesophageal Reflex Disorder
- ☐ Glaucoma
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Heart Murmur/Atrial Fibrilation
- ☐ Hemophilia
- ☐ Hepatitis (B or C)
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Mental Disorders
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ STDs
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tonsillectomy (have had)
- ☐ Trauma to Head or Neck

Dental History

Please list the reason why you scheduled an appointment with our dental office? *

_____

Approximate date of last dental visit * _____

Name of Dentist *

_____

Do you have any mouth pain at this time? * ◯ Yes ◯ No

Do you have any pain in your face or jaws? * ◯ Yes ◯ No

Do you or have you been told that you clench or grind your teeth? * ◯ Yes ◯ No

Do you have any "clicks or pops" in your jaws upon opening or closing? * ◯ Yes ◯ No

Do you currently wear any dental appliances (partials, retainers, nightguards, sleep apnea devices)? * ◯ Yes ◯ No

Have you received periodontal treatment in the past (i.e. root planing, "deep cleaning")? * ◯ Yes ◯ No

Have you ever had gum surgery or been under the care of a periodontist? * ◯ Yes ◯ No

Sleep Apnea Evaluation

Weight * _____

Height * _____

Neck Size (Shirt Collar Size) * _____

What are the symptoms/complaints for which you are seeking treatment? *

- ☐ Frequent heavy snoring
- ☐ Significant daytime drowsiness
- ☐ Difficulty falling asleep
- ☐ Feeling un-refreshed in the morning
- ☐ Morning headache
- ☐ Neck pain
- ☐ Snoring affects the sleep of others
- ☐ I have been told that "I stop breathing" when sleeping
- ☐ Gasping or chokng during sleep
- ☐ Morning hoarseness
- ☐ Jaw pain/clicking
- ☐ Nocturnal teeth grinding/clenching

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, incontrast to just feeling tired? This refers to your usual way of life in recent times.Even if you have not done these things recently, try to work out how they will have affected you. Use the following scale to mark the most appropriate box for each situation.

0=would never doze 1=slight chance of dozing
2=moderate chance of dozing 3=high chance of dozing

Sittng and Reading *

◯ 0=would never doze ◯ 1=slight chance of dozing ◯ 2=moderate chance of dozing ◯ 3=high chance of dozing

Watch TV *

◯ 0=would never doze ◯ 1=slight chance of dozing ◯ 2=moderate chance of dozing ◯ 3=high chance of dozing

Sitting inactive, in a puplic place (theater,meeting, etc.) *

◯ 0=would never doze ◯ 1=slight chance of dozing ◯ 2=moderate chance of dozing ◯ 3=high chance of dozing

As a passenger in a car for an hour without a break *

◯ 0=would never doze ◯ 1=slight chance of dozing ◯ 2=moderate chance of dozing ◯ 3=high chance of dozing

Lying down to rest in the afternoon when circumstances permit *

◯ 0=would never doze ◯ 1=slight chance of dozing ◯ 2=moderate chance of dozing ◯ 3=high chance of dozing

Sitting and talking to someone *

◯ 0=would never doze ◯ 1=slight chance of dozing ◯ 2=moderate chance of dozing ◯ 3=high chance of dozing

Sitting quietly after lunch without lunch without alcohol *

◯ 0=would never doze ◯ 1=slight chance of dozing ◯ 2=moderate chance of dozing ◯ 3=high chance of dozing

In a car, while stopped for a few minutes in traffic *

◯ 0=would never doze ◯ 1=slight chance of dozing ◯ 2=moderate chance of dozing ◯ 3=high chance of dozing

*

☐ I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. 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 fees for treatment regardless of insurance coverage.

Response Date: ____/____/_____