Name_____
Birthday_____

Physician's name_____ Physician's Ph #_____

Are you being treated by a physician now? Yes_____ No_____

Please list any medications you are currently taking and the reason for them._____
_____
_____

Are you allergic to any medications? Yes_____ No _____

If yes what?
_____

Do you have or have you had a history of the following:

__Aids
__Allergies
__Anemia
__Arthritis
__**Artificial Joints**
__Asthma
__Blood Disease
__Cancer/Tumors
__Diabetes
__Dizziness
__Epilepsy
__Excessive bleeding
__Fainting
__Glaucoma
__Growths
__Head Injuries
__Heart Disease
__Heart Attack
__Hepatitis
__High Blood Pressure
__Kidney Disease
__Liver Disease
__Mental Disorders
__Nervous Disorders
__Pregnancy (current)
__Radiation Treatment
__Respiratory Problems
__Stomach Problems
__ Stroke
__TMJ Disorder
__Ulcers
__Thyroid Problems
__Weight Gain
__Family history of Sleep Apnea
__Diagnosis of Sleep Apnea
__ Have taken a sleep test

Do you Smoke? Yes___ No___ How long?_____ Packs/Day_____
Do you E-Cig/Vape yes___ No ___ How Long?_____
Do you chew tobacco? Yes___ No___ How long?_____
Did you ever take the diet drug Phen Fen? Yes ___ No ___ If so: have you seen your doctor regarding this medication? Yes ___ No ___
Have you had any problems or complications associated with local Anesthetic, Nitrous Oxide or IV Sedations? Yes___ No___

Sleep Screening

Height :

ft

in

Weight :

lbs

Blood Pressure:

/ mm

Head, neck or Jaw pain? Never Sometimes Mostly Always

Jaw popping or clicking? Never Sometimes Mostly Always

Gasp for air while sleeping? Never Sometimes Mostly Always

Difficulty staying asleep? Never Sometimes Mostly Always

Daytime tiredness? Never Sometimes Mostly Always

Mornings feel great? Never Sometimes Mostly Always

Average hours of sleep Below 7 Above 7

Are you currently using a C-Pap or any other sleep therapy appliance? Yes No