TMJ- Sleep Colorado 1619 N. Greenwood, Suite 308, Pueblo, CO 81003

DENTAL MEDICAL HISTORY

Patient Name: _____/_____/_____
Age: _____ Date of Birth: _____/_____/_____ ☐ Male ☐Female
Height: _____ Weight:_____ Occupation_____
Address: _____
City _____ State _____ Zip Code _____
Phone #: _____ Work Phone # _____
Cell #: _____ Ok to Text? Yes No
Email _____SS#: _____
Spouse Information: Name: _____ DOB: _____
How were you referred to our office? ☐Physician ☐Sleep Specialist ☐Dentist ☐Friend ☐Website ☐Radio☐TV ☐Newspaper ☐Other _____
Name of Primary Care Physician: _____
Dentist: _____ Office use: Ht:____ Wt:_____O2___ Pulse____

I. CHIEF COMPLAINTS: WHAT IS THE CHIEF COMPLAINT THAT YOU ARE SEEKING TREATMENT IN THIS OFFICE? Please identify your chief complaint as #1, list all other symptoms in priority #2-9 for example)

_____ Headache pain
_____ Ear Pain
_____ Jaw Pain
_____ Pain when chewing
_____ Facial Pain
_____ Eye Pain
_____ Throat Pain
_____ Neck Pain
_____ Shoulder Pain
_____ Back Pain
_____ Limited ability to open
_____ Jaw joint locking
_____ Jaw joint noises
_____ Ear congestion
_____ Sinus congestion
_____ Dizziness
_____ Tinnitus (ringing ears)
_____ Muscle twitching

_____ Vision problems
_____ Kicking or jerking leg
_____ Swelling in ankles or feet
_____ Morning Hoarseness
_____ Dry mouth upon waking
_____ Fatigue
_____ Difficulty falling asleep
_____ Tossing and turning frequently
_____ Repeated awakening
_____ Feeling unrefreshed in the a.m.
_____ Significant daytime drowsiness
_____ Frequent heavy snoring
_____ Affects sleep of others
_____ Gasping when waking
_____ Told that "I stop breathing" during sleep
_____ Night-time choking spells
_____ Unable to tolerate C-Pap
_____ Teeth grinding

_____Other:_____

For what reason(s) are you seeking treatment at this office? _____
_____
What are the results you are hoping to get from treatment?_____
_____

II. SLEEP HISTORY:

Please answer the following questions regarding your sleep history.

Do you use an alarm to wake up? ☐ Yes ☐ No
Do you take naps? ☐ Yes ☐ No
Hours of Sleep Daily:

- ☐ < 6 hours
- ☐ < 6-8 hours
- ☐ > 8 hours

Average Bedtime: _____
Average Wake Time: _____
Sleep Position:

- ☐ Back
- ☐ Stomach
- ☐ Side

Upon waking in the morning, do you feel?

Groggy	☐ Yes	☐ No
Tired	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Refreshed	☐ Yes	☐ No

Insomnia:

Trouble Falling Asleep:	☐ Yes	☐ No
Trouble Returning to Sleep:	☐ Yes	☐ No
Shift work:	☐ Yes	☐ No

Quality and Activity:

Light sleeper	☐ Yes	☐ No
Restless	☐ Yes	☐ No
Uncomfortable leg sensation	☐ Yes	☐ No
Kicking	☐ Yes	☐ No
Teeth grinding	☐ Yes	☐ No

Sleep Behavior:

Walking	☐ Yes	☐ No
Talking	☐ Yes	☐ No
Violence	☐ Yes	☐ No

Childhood History:

Snored	☐ Yes	☐ No
Sleep Walked	☐ Yes	☐ No
Bedwetting	☐ Yes	☐ No
Scary Dreams	☐ Yes	☐ No

PREVIOUS DIAGNOSIS: PSG in sleep lab or Home Sleep Study:

☐ PSG ☐ HST ☐ Not available

Date: _____Physician Name_____
Sleep Lab:_____ Facility
Location:_____

Does your family have a history of OSA? Yes No

EPWORTH SLEEPINESS SCALE

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they have affected you. Use the following scale to check the most appropriate number for each situation.
0=never doze 1=slight chance of dozing 2=moderate chance of dozing 3=high chance of dozing

	0	1	2	3
Sitting and reading	O	O	O	O
Watching TV	O	O	O	O
Sitting, inactive, in a public place (theater, meeting, etc.)	O	O	O	O
As a passenger in a car for an hour without a break	O	O	O	O
Lying down to rest in the afternoon when circumstances permit	O	O	O	O
Sitting and talking to someone	O	O	O	O
Sitting quietly after lunch without alcohol	O	O	O	O
In a car, while stopped for a few minutes in traffic	O	O	O	O

Score _____

III. REVIEW OF SYSTEMS:

Do you have any of the following problems or conditions?

Constitutional

Underweight	☐NOW	☐PAST	☐NEVER
Overweight	☐NOW	☐PAST	☐NEVER
Weight loss	☐NOW	☐PAST	☐NEVER
Fatigue	☐NOW	☐PAST	☐NEVER
Fevers	☐NOW	☐PAST	☐NEVER
Chronic fatigue syndrome	☐NOW	☐PAST	☐NEVER

Ear, Nose, Throat & Mouth

Dry mouth	☐NOW	☐PAST	☐NEVER
Mouth breathing	☐NOW	☐PAST	☐NEVER
Tongue thrust	☐NOW	☐PAST	☐NEVER
Large tonsils	☐NOW	☐PAST	☐NEVER
Ear aches/infections	☐NOW	☐PAST	☐NEVER
Hearing loss	☐NOW	☐PAST	☐NEVER
Tinnitus (ringing of ears)	☐NOW	☐PAST	☐NEVER
Post nasal drainage	☐NOW	☐PAST	☐NEVER
Headaches	☐NOW	☐PAST	☐NEVER

Eyes

Poor vision	☐NOW	☐PAST	☐NEVER
Dry eyes	☐NOW	☐PAST	☐NEVER
Eye pain	☐NOW	☐PAST	☐NEVER

Allergic/Immunologic

Allergies	☐NOW	☐PAST	☐NEVER
Asthma	☐NOW	☐PAST	☐NEVER
Sinus problems	☐NOW	☐PAST	☐NEVER
Lupus	☐NOW	☐PAST	☐NEVER
HIV/Aids	☐NOW	☐PAST	☐NEVER

Respiratory

Lung disease	☐NOW	☐PAST	☐NEVER
Shortness of breath	☐NOW	☐PAST	☐NEVER
Coughing	☐NOW	☐PAST	☐NEVER
Wheezing	☐NOW	☐PAST	☐NEVER
Snoring	☐NOW	☐PAST	☐NEVER

Cardiovascular

Heart disease	☐NOW	☐PAST	☐NEVER
CVA/Stroke	☐NOW	☐PAST	☐NEVER
Pace maker	☐NOW	☐PAST	☐NEVER
Heart palpitations	☐NOW	☐PAST	☐NEVER
Chest pain	☐NOW	☐PAST	☐NEVER
Vascular disease	☐NOW	☐PAST	☐NEVER

Hypertension	☐NOW	☐PAST	☐NEVER
Swollen hands & feet	☐NOW	☐PAST	☐NEVER

Gastrointestinal

Gastric reflux	☐NOW	☐PAST	☐NEVER
Diarrhea	☐NOW	☐PAST	☐NEVER
Constipation	☐NOW	☐PAST	☐NEVER
Stomach ulcers	☐NOW	☐PAST	☐NEVER
Gall bladder problems	☐NOW	☐PAST	☐NEVER

Genito/Urinary

Kidney disease	☐NOW	☐PAST	☐NEVER
Prostate problems	☐NOW	☐PAST	☐NEVER
Painful, frequent urination	☐NOW	☐PAST	☐NEVER
Impotence	☐NOW	☐PAST	☐NEVER
Menstrual cramping	☐NOW	☐PAST	☐NEVER
Pregnancy	☐NOW	☐PAST	☐NEVER
Birth control	☐NOW	☐PAST	☐NEVER
Menopausal problems	☐NOW	☐PAST	☐NEVER
Hepatitis	☐NOW	☐PAST	☐NEVER

Integumentary (Skin)

Dry skin	☐NOW	☐PAST	☐NEVER
Rashes	☐NOW	☐PAST	☐NEVER
Brittle nails	☐NOW	☐PAST	☐NEVER
Hair loss	☐NOW	☐PAST	☐NEVER
Wounds that won't heal	☐NOW	☐PAST	☐NEVER

Musculoskelatal

Back aches	☐NOW	☐PAST	☐NEVER
Scoliosis	☐NOW	☐PAST	☐NEVER
Fibromyalgia	☐NOW	☐PAST	☐NEVER
Neck ache	☐NOW	☐PAST	☐NEVER
Limited range of motion of neck	☐NOW	☐PAST	☐NEVER
Joint pain	☐NOW	☐PAST	☐NEVER
Loss of strength	☐NOW	☐PAST	☐NEVER
Osteoarthritis	☐NOW	☐PAST	☐NEVER

Neurological

Numb fingers & hands	☐NOW	☐PAST	☐NEVER
Paralysis	☐NOW	☐PAST	☐NEVER
Dizziness	☐NOW	☐PAST	☐NEVER
Memory loss	☐NOW	☐PAST	☐NEVER
Fainting spells	☐NOW	☐PAST	☐NEVER
Seizures/epilepsy	☐NOW	☐PAST	☐NEVER
Shaking/twitching	☐NOW	☐PAST	☐NEVER
Hand tremors	☐NOW	☐PAST	☐NEVER
Parkinson's disease	☐NOW	☐PAST	☐NEVER

Psychiatric

Emotional upsets	☐NOW	☐PAST	☐NEVER
Depression	☐NOW	☐PAST	☐NEVER
Psychiatric disorder	☐NOW	☐PAST	☐NEVER
ADHD	☐NOW	☐PAST	☐NEVER
Learning disability	☐NOW	☐PAST	☐NEVER
Alcoholism	☐NOW	☐PAST	☐NEVER
Drug abuse	☐NOW	☐PAST	☐NEVER

Hematologic/Lymphatic

Anemia/blood disorders	☐NOW	☐PAST	☐NEVER
Abnormal bleeding	☐NOW	☐PAST	☐NEVER
Cancer	☐NOW	☐PAST	☐NEVER
Chemo/radiation	☐NOW	☐PAST	☐NEVER
Nose bleeds	☐NOW	☐PAST	☐NEVER

Endocrine

Rheumatoid arthritis	☐NOW	☐PAST	☐NEVER
Cold Hands & feet	☐NOW	☐PAST	☐NEVER
Hypothyroidism	☐NOW	☐PAST	☐NEVER
Diabetes	☐NOW	☐PAST	☐NEVER
Hypoglycemia	☐NOW	☐PAST	☐NEVER

Other:	☐NOW	☐PAST	☐NEVER

NOTES: PLEASE ELABORATE FURTHER ON ANY DISEASE OR DISORDER:

_____
_____
_____
_____
_____

Medications:

Medication:	Dose	Rx	Reason

Allergies to Medications:

Antibiotics	☐ Yes	☐ No
Barbituarates	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Iodine	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Sedatives	☐ Yes	☐ No
Sulfur Drugs	☐ Yes	☐ No
Foods	☐ Yes	☐ No

Other: _____

IV. PAST FAMILY AND SOCIAL HISTORY:

A. PAST HISTORY:

Have you sustained any injury due to an accident? ☐ Yes ☐ No

If yes;

Date of Accident	Injuries Sustained

Previous Surgeries? ☐ Yes ☐ No

Date of Surgery	Type of Surgery

B. FAMILY HISTORY:

Has any parent or sibling experienced any of the following conditions?

Heart disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
HBP	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Depression	☐ Yes	☐ No			

C. SOCIAL HISTORY:

1. Recent Alcohol Consumption:
   - ☐ Never
   - ☐ 1-3 drinks per week
   - ☐ 1-2 drinks per day
   - ☐ > 2 drinks per day

2. History of alcoholism: ☐ Yes ☐ No

3. Recent Tobacco Usage:
   - ☐ Never
   - ☐ Less than 1 pack per week
   - ☐ Less than 1 pack per day
   - ☐ 1 pack or more per day

   History of smoking/tobacco use: ☐ Yes ☐ No

   Years of use: _____ yrs.

4. Caffeine intake:
   a. Most common form of caffeine intake:

      ☐ Coffee ☐ Energy drinks ☐ Soda ☐ Caffine capsule

      _____ Servings of caffeine in the morning

      _____ Servings of caffeine in the afternoon

      _____ Servings of caffeine in the evening

   Other form of caffeine intake (i.e. coffee, energy drinks, soda, caffeine capsule) and time of day they are taken:

   _____

Notes:

Anything else you would like to mention regarding your family or social history:

_____

_____

_____

_____

_____

PATIENT SIGNATURE

_____

DATE