

Patient Medical History

Patient's Name: _____ Date of appointment: _____

Physician: _____ Office phone: _____ Date of last medical exam: _____

1. Are you under medical treatment now?..... Y N

2. Are you taking any medication(s) including non-prescription medicine?..... Y N

Please list **all** medications you are taking:

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.....
.....
.....
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.....
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.....
.....

3. Do you use tobacco?..... Y N

4. Do you use controlled substances?..... Y N

5. *For Women only:*

Are you pregnant or think you may be pregnant?..... Y N

6. Are you allergic to or have you had any reactions to the following? Circle which:

Local anesthetics (i.e. novocaine)

Penicillin or other antibiotics

Sulfa drugs

Acrylics

Iodine

Aspirin

Any metals (e.g. nickel, mercury, etc.)

Latex rubber

Sedatives

Barbiturates

Other (please list) _____

7. Do you have a family history of snoring or sleep apnea?..... Y N

Please see next page

8. Do you have or have you had any of the following?

Acid reflux.....	Y N	Epilepsy/convulsions.....	Y N	Liver disease.....	Y N
Asthma.....	Y N	Fainting/seizures.....	Y N	Low blood pressure.....	Y N
Anemia.....	Y N	Frequent headaches.....	Y N	Mitral valve prolapse.....	Y N
Angina.....	Y N	Frequently tired.....	Y N	Radiation therapy.....	Y N
Arthritis.....	Y N	Glaucoma.....	Y N	Recent weight loss/gain.....	Y N
Breathing problems.....	Y N	Hay fever/allergies	Y N	Rheumatic fever.....	Y N
Cancer	Y N	Heart attack.....	Y N	Stroke.....	Y N
Cardiac pacemaker.....	Y N	Heart disease.....	Y N	Swollen ankles.....	Y N
Diabetes.....	Y N	Heart murmur.....	Y N	Thyroid problems.....	Y N
Easily winded.....	Y N	Hepatitis/jaundice.....	Y N	Tuberculosis.....	Y N
Emphysema.....	Y N	High blood pressure.....	Y N	Leukemia	Y N
Depression.....	Y N	Kidney diseases.....	Y N		
Mental illness.....	Y N				
Diagnosis?					

Patient Dental History

Do your gums bleed while brushing or flossing?..... Y N
Do you feel pain in any of your teeth?..... Y N
Have you had any head, neck or jaw injuries?..... Y N
Have you ever experienced any of the following problems in your jaw?
 Clicking.....Y N
 Pain (joint, ear, side of face)..... Y N
 Difficulty in opening or closing your mouth..... Y N
 Difficulty in chewing..... Y N
Do you grind or clench your teeth?.....Y N
Have you had orthodontic treatment?..... Y N
Do you wear full or partial dentures?..... Y N

I certify that I have read and understand the above information to the best of my knowledge. The questions have been accurately answered. I understand that providing inaccurate answers to my medical history can be dangerous to my health. I authorize Sleep Dentists of New England to release any information, including diagnosis and records of any treatment or examination to third party payers and/or health practitioners. I understand that my medical insurance may not pay for any of my treatment and I agree to be responsible for payment of all services rendered on my behalf.

Patient Signature: _____ Date: _____