

# Patient Medical History

Patients 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)..... Y N

including non-prescription medicine?  
Please list **all** medications you are taking:

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

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

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

**High Blood Pressure** ..... Y N

**Heart Attack** ..... Y N

Rheumatic Fever ..... Y N

Swollen Ankles ..... Y N

Fainting / Seizures ..... Y N

Asthma ..... Y N

Low Blood Pressure ..... Y N

Epilepsy / Convulsions ..... Y N

Leukemia ..... Y N

**Diabetes** ..... Y N

Mitral Valve Prolapse ..... Y N

Kidney Diseases ..... Y N

**Thyroid Problems** ..... Y N

Depression ..... Y N

**Heart Disease** ..... Y N

**Cardiac Pacemaker** ..... Y N

Heart Murmur ..... Y N

**Angina** ..... Y N

**Frequently Tired** ..... Y N

Anemia ..... Y N

Emphysema ..... Y N

Cancer ..... Y N

Arthritis ..... Y N

Heart Trouble ..... Y N

**Do you have frequent headaches?** Y N

Hepatitis /jaundice ..... Y N

**Acid Reflux** ..... Y N

Mental Illness ..... Y N (diagnosis \_\_\_\_\_)

Chest Pains ..... Y N

Easily Winded ..... Y N

**Stroke** ..... Y N

**Hay Fever/ Allergies** ..... Y N

Tuberculosis ..... Y N

Radiation Therapy ..... Y N

Glaucoma ..... Y N

**Recent Weight Loss/ Gain** ..... Y N

Liver Disease ..... Y N

Breathing Problems ..... Y N

Patient Dental History:

Do your gums bleed while brushing or flossing?

Do you feel pain to any of your teeth?

Have you had any head, neck or jaw injuries?

Have you ever experienced any of the following problems in your jaw?

Clicking

**Pain (joint, ear, side of face)**

**Difficulty in opening or closing**

**Difficulty in chewing**

**Do you grind or clench your teeth?** Y N

Have you had orthodontic treatment? Y N

**Do you wear removable complete or partial dentures?** Y N

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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 Dr. Demko 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.