

Comprehensive Health Questionnaire

Patient Information

Mr. Ms. Miss Mrs. Dr.

First Name: _____ Middle Initial: _____ Last Name: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Referred by: _____ DDS MD DO DC Other _____

Address and/or Phone Number of Healthcare Provider: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Contact Number: _____

Email: _____

Type of Employment: _____ Place of Employment: _____

Responsible Party (if different than patient): _____

Address: _____ City: _____ State: _____ Zip: _____

Family Physician: _____ Phone Number: _____

Family Dentist: _____ Phone Number: _____

What is your chief concern and reason for this visit: _____

What are the results you are seeking from treatment: _____

Do you currently experience any of the following symptoms?

Please number your chief complaints 1-4

	Recent	Chronic		Recent	Chronic
___ Headache (inside your head)	<input type="checkbox"/>	<input type="checkbox"/>	___ Morning Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
___ Headache (outside your head)	<input type="checkbox"/>	<input type="checkbox"/>	___ Dry Mouth Upon Waking	<input type="checkbox"/>	<input type="checkbox"/>
___ Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
___ Chewing Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Difficulty Falling Asleep	<input type="checkbox"/>	<input type="checkbox"/>
___ Face Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Tossing and Turning Frequently	<input type="checkbox"/>	<input type="checkbox"/>
___ Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Repeated Awakening	<input type="checkbox"/>	<input type="checkbox"/>
___ Throat Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Feeling Un-refreshed in the Morning	<input type="checkbox"/>	<input type="checkbox"/>
___ Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Morning Headaches	<input type="checkbox"/>	<input type="checkbox"/>
___ Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Nighttime Urination	<input type="checkbox"/>	<input type="checkbox"/>
___ Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
___ Dyskinesia	<input type="checkbox"/>	<input type="checkbox"/>	___ Vivid Dreams	<input type="checkbox"/>	<input type="checkbox"/>
___ Difficulty Opening Mouth	<input type="checkbox"/>	<input type="checkbox"/>	___ Sore Jaw Upon Waking	<input type="checkbox"/>	<input type="checkbox"/>
___ Difficulty Closing Mouth	<input type="checkbox"/>	<input type="checkbox"/>	___ Significant Daytime Drowsiness	<input type="checkbox"/>	<input type="checkbox"/>
___ Noises in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	___ Affect Sleep of Others	<input type="checkbox"/>	<input type="checkbox"/>
___ Ear Stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	___ Short of Breath when Waking	<input type="checkbox"/>	<input type="checkbox"/>
___ Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	___ Told "I stop breathing" During Sleep	<input type="checkbox"/>	<input type="checkbox"/>
___ Ringing in Ears (Tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>	___ Night-Time Choking Spells	<input type="checkbox"/>	<input type="checkbox"/>
___ Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	___ Unable to Tolerate C-Pap	<input type="checkbox"/>	<input type="checkbox"/>
___ Muscle Spasm	<input type="checkbox"/>	<input type="checkbox"/>	___ Tooth Grinding	<input type="checkbox"/>	<input type="checkbox"/>
___ Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	___ Teeth Crowding	<input type="checkbox"/>	<input type="checkbox"/>
___ Kicking or jerking leg repeatedly	<input type="checkbox"/>	<input type="checkbox"/>	___ Frequent Heavy Snoring	<input type="checkbox"/>	<input type="checkbox"/>
___ Swelling in ankles or feet	<input type="checkbox"/>	<input type="checkbox"/>	___ Acid Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
___ Numbness (Localized)	<input type="checkbox"/>	<input type="checkbox"/>			
___ Nerve Pain	<input type="checkbox"/>	<input type="checkbox"/>			
___ Dental Changes	<input type="checkbox"/>	<input type="checkbox"/>			
___ Teeth Spacing	<input type="checkbox"/>	<input type="checkbox"/>			
___ Teeth Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>			
___ Changes with your Bite	<input type="checkbox"/>	<input type="checkbox"/>			
___ Any Other Symptoms not listed above			_____		

Patient/Parent Signature: _____

Date: _____

Sleep Conditions - Please select the yes or no answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Position? Side Back Stomach Varies Yes No

Bed Partner? Yes No

Is it easy to fall asleep? Yes No

Do you wake often during the night? Yes No

Do you feel rested upon waking? Yes No

Stopped breathing during sleep? Yes No

Have you ever had a Sleep Study? HST PSG No Date: _____ Result: _____

Previous Positive Airway Pressure Devices Used? CPAP BiPAP ASV APAP

Do you currently use a PAP Device? Yes No Type: _____

Previous Oral Appliance? Yes No Type: _____

Sleep Location? Bed Couch Chair Other

Average hours of sleep per night? _____

Average hours of sleep per day? _____

Cough, gasps or snorts on waking? Yes No

Observed pauses in breath? Yes No

Allergic Reactions

Please check any and all medications or substance that have caused an allergic reaction

- Anesthetics Antibiotics Aspirin
 - Barbiturates Codeine Iodine
 - Latex Metals Plastics
 - Penicillin Sedatives Sulfa
 - Food Allergies/Sensitivities _____
- Other: _____

Current Medications

Please list all medications and supplements (over-the-counter and prescription) you are taking and the reason you take them.

Medication	Dosage	Reason for Taking

See attached list

Previous Treatment, Medications and Other Therapies Attempted For The Condition We Are Evaluating

Treatment/Med/Therapy	Doctor/Provider	Approx. Date of Tx	Helpful (y/n)

See attached list

Health And Medical History

- Are you currently pregnant? Yes No
- Do you drink 4 or more cups of coffee per day? Yes No
- Do you smoke tobacco? Yes No
- Do you consume alcohol or take sedatives? Yes No
- Do you have trouble breathing through your nose? Yes No
- Have you had prior orthodontic treatments? Yes No
- Have you sustained injury to: Head Neck Face Teeth
- Other: _____

Surgical History - Have you had any of the following:

- General Anesthesia Yes No
- Adenoids Removed Yes No
- Tonsils Removed Yes No
- Jaw Joint Surgery Yes No
- Orthognathic Surgery Yes No
- Oral Surgery Yes No
- Removal of Third Molar (Wisdom Teeth) Yes No

Other types of surgery: _____

Additional Health And Medical History

Do you have or have you experienced any of the following

Anemia Yes No Fam Hx
Anxiety Yes No Fam Hx
Asthma Yes No Fam Hx
Bleeding Easily Yes No Fam Hx
Birth Defects Yes No Fam Hx
Bruising Easily Yes No Fam Hx
Cancer of _____ Yes No Fam Hx
Chemo Yes No Fam Hx
Chronic Fatigue Yes No Fam Hx
Cold Hands and Feet Yes No Fam Hx
COPD Yes No Fam Hx
Depression Yes No Fam Hx
Diabetes Yes No Fam Hx
Difficulty Concentrating Yes No Fam Hx
Difficulty Breathing at Night Yes No Fam Hx
Dizziness Yes No Fam Hx
Emphysema Yes No Fam Hx
Epilepsy Yes No Fam Hx
Excessive Thirst Yes No Fam Hx
Fainting Yes No Fam Hx
Fibromyalgia Yes No Fam Hx
Fluid Retention Yes No Fam Hx
Frequent Colds/Flu Yes No Fam Hx
Frequent Cough Yes No Fam Hx
Frequent Ear Infections Yes No Fam Hx
Frequent Sore Throat Yes No Fam Hx
Awakening from Sleep ____ x Yes No Fam Hx
Gastroesophageal Reflux Yes No Fam Hx
Glaucoma Yes No Fam Hx
Hay Fever Yes No Fam Hx
Hearing Impairment Yes No Fam Hx
Heart Attack Yes No Fam Hx
Heart Disease Yes No Fam Hx
Heart Murmur Yes No Fam Hx
Heart Pacemaker Yes No Fam Hx
Heart Palpitations Yes No Fam Hx
Heart Valve Replacement Yes No Fam Hx
Hemophilia Yes No Fam Hx
Hepatitis Yes No Fam Hx
High Blood Pressure Yes No Fam Hx
History of Substance Abuse Yes No Fam Hx
Huntington's Disease Yes No Fam Hx

Hypoglycemia Yes No Fam Hx
Insomnia Yes No Fam Hx
Intestinal Disorder Yes No Fam Hx
Irregular Heartbeat Yes No Fam Hx
Kidney Disease Yes No Fam Hx
Leukemia Yes No Fam Hx
Liver Disease Yes No Fam Hx
Low Blood Pressure Yes No Fam Hx
Meniere's Disease Yes No Fam Hx
Memory Loss Yes No Fam Hx
Migraines Yes No Fam Hx
Mitral Valve Prolaps Yes No Fam Hx
Multiple Sclerosis Yes No Fam Hx
Muscle Aches Yes No Fam Hx
Muscle Fatigue Yes No Fam Hx
Muscle Spasms Yes No Fam Hx
Muscular Dystrophy Yes No Fam Hx
Neuralgia Yes No Fam Hx
Nervous system Disorder Yes No Fam Hx
Osteoarthritis Yes No Fam Hx
Osteoporosis Yes No Fam Hx
Ovarian Cyst Yes No Fam Hx
Parkinson's Disease Yes No Fam Hx
Poor Circulation Yes No Fam Hx
Psychiatric Care Yes No Fam Hx
Radiation Yes No Fam Hx
Recent Weight Gain Yes No Fam Hx
Recent Weight Loss Yes No Fam Hx
Rheumatic Fever Yes No Fam Hx
Rheumatoid Arthritis Yes No Fam Hx
Scarlet Fever Yes No Fam Hx
Shortness of Breath Yes No Fam Hx
Skin Disorder Yes No Fam Hx
Sinus Problems Yes No Fam Hx
Slow Healing Sores Yes No Fam Hx
Speech Difficulties Yes No Fam Hx
Stroke Yes No Fam Hx
Swollen or Painful Joints Yes No Fam Hx
Thyroid Disease Yes No Fam Hx
Tired Muscles Yes No Fam Hx
Tuberculosis Yes No Fam Hx
Urinary Tract Disorder Yes No Fam Hx

Additional Symptoms

Head Pain

	<i>Location</i> <small>L = Left R = Right B = Bilateral</small>	<i>Recent</i>	<i>Chronic</i> <small>(over 6mo.)</small>	<i>Severity</i> <small>Mild Mod Severe</small>	<i>Duration</i> <small>Hrs Days Wks</small>	<i>Frequency</i> <small>Occ. Freq Constant</small>
Temple Area	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Back of Head	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Forehead	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Top of Head	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
All of Head	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Jaw Pain

Jaw pain with opening	<input type="checkbox"/> L	<input type="checkbox"/> R
Jaw pain when chewing	<input type="checkbox"/> L	<input type="checkbox"/> R
Jaw pain at rest	<input type="checkbox"/> L	<input type="checkbox"/> R

Jaw Joint Sound

Jaw sounds with opening	<input type="checkbox"/> L	<input type="checkbox"/> R
Jaw sounds when chewing	<input type="checkbox"/> L	<input type="checkbox"/> R

Jaw Locking

Jaw locks closed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Jaw locks open	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Jaw Joint Symptoms

Teeth clenching	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Day	<input type="checkbox"/> Night
Teeth grinding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Day	<input type="checkbox"/> Night

Eye Related Conditions

Blurred vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Double vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Pain or pressure behind the eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Extreme sensitivity to light	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wear of glasses or contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Ear Related Conditions

Buzzing in ears	<input type="checkbox"/> L	<input type="checkbox"/> R
Ear Congestion	<input type="checkbox"/> L	<input type="checkbox"/> R
Ear pain	<input type="checkbox"/> L	<input type="checkbox"/> R
Hearing Loss	<input type="checkbox"/> L	<input type="checkbox"/> R
Itchiness/stuffiness	<input type="checkbox"/> L	<input type="checkbox"/> R

Pain behind the ear	<input type="checkbox"/> L	<input type="checkbox"/> R
Pain in front of ear	<input type="checkbox"/> L	<input type="checkbox"/> R
Recurrent ear infections	<input type="checkbox"/> L	<input type="checkbox"/> R
Ringling in the ear (tinnitus)	<input type="checkbox"/> L	<input type="checkbox"/> R

Throat Related Conditions

Chronic sore throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty Swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swollen glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Thyroid enlargement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tightness in throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Feeling of foreign object in throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Neck related Conditions

Limited movement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neck pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Numbness in hands/fingers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling in neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Shoulder Conditions

Pain in Shoulder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stiffness in Shoulder	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Tingling in fingers/hands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Back Conditions

Low Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Middle Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Upper Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Scoliosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sciatica	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Mouth/Nose Conditions

Chronic Sinusitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dry Mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Snoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Broken Teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Biting Cheeks	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Burning Tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No

History of Symptoms

On what date, or approximate date, did the condition you are seeking treatment for occur? _____

Are any of the conditions listed or was your chief complaint caused by a motor vehicle accident? Yes No

If yes, what conditions: _____ Date of accident: _____

Does any family member have a sleep breathing disorder? Yes No If yes, explain: _____

Adult - Complete this section

1. DAYTIME SLEEPINESS EVALUATION - EPWORTH SLEEPINESS SCALE

For the following situations, answer with one of the following numbers:

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

Situation	Score	Situation	Score
Sitting and reading	_____	Sitting and talking to someone	_____
Watching Television	_____	Sitting quietly after a lunch (no alcohol)	_____
Sitting, inactive public place	_____	In a car, while stopped for a few minutes in traffic	_____
As a passenger in a car for an hour without a break	_____	Lying down to rest in the afternoon when circumstances permit	_____

TOTAL SCORE _____

2. NIGHTTIME SLEEPINESS EVALUATION

Developed by David White, M.D., Harvard Medical School, Boston, MA

- 1. Snoring Score
 - a) Do you snore on most nights (>3 nights per week)?
 - Yes (2) No (0) _____
 - b) Is your snoring loud? Can it be heard through a door or wall?
 - Yes (2) No (0) _____

- 2. Has it ever been reported to you that you stop breathing or gasp during sleep?
 - Never (0) Occasionally (3) Frequently (5) _____

- 3. What is your collar size?
 - Male: Less than 17 inches (0) More than 17 inches (5)
 - Female: Less than 16 inches (0) More than 16 inches (5) _____

- 4. Do you occasionally fall asleep during the day when:
 - a) You are busy or active
 - Yes (2) No (0) _____
 - b) You are driving or stopped at a light?
 - Yes (2) No (0) _____

- 5. Have you had or are you being treated for high blood pressure?
 - Yes (2) No (0) _____

TOTAL _____

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, third party billing companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient/Parent Signature: _____

Date: _____

3. Child - Complete this section

BEARS SLEEP SCREENING

The “BEARS” instrument is divided into five major sleep domains, providing a comprehensive screen for the major sleep disorders affecting children in the 2- to 18-year old range. Each sleep domain has a set of age-appropriate “trigger questions” for use in the clinical interview.

B = bedtime problems

E = excessive daytime sleepiness

A = awakenings during the night

R = regularity and duration of sleep

S = snoring

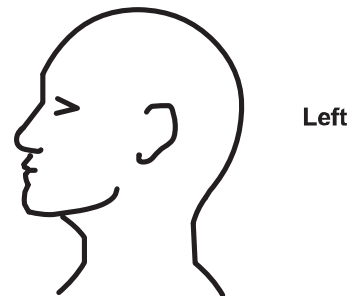
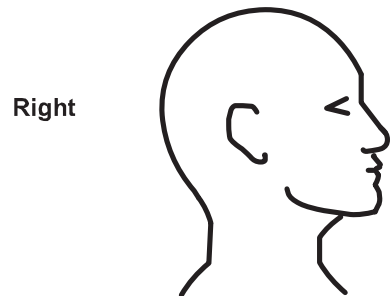
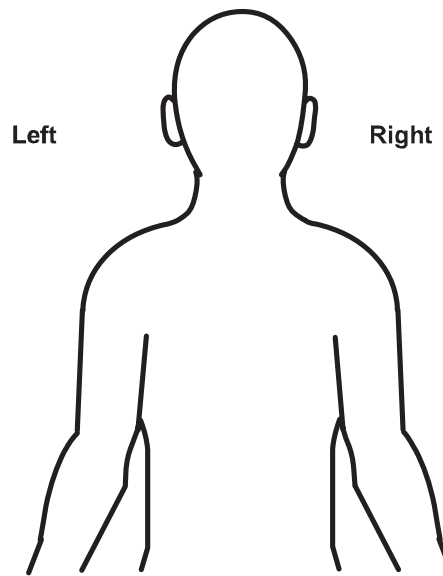
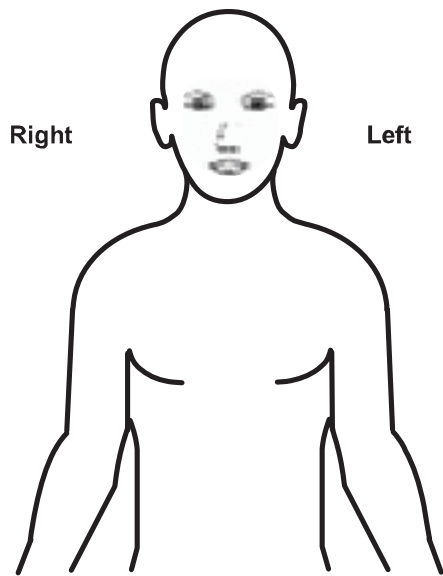
A parent answers questions in **black**, the subject child answers questions written in **blue**:

Symptom	Age Toddler/Preschool (2-5 years)	Age School Age (6-12 years)	Age Adolescent (13-18 years)
1. Bedtime Problems	Does your child have any problems going to bed? Y N	Does your child have any problems at bedtime? (P) Y N Do you have any problems going to bed? (C)	Do you have any problems falling asleep at bedtime? (C) Y N
2. Excessive Daytime Sleepiness	Does your child seem overtired or sleepy a lot during the day? Y N	Does your child have difficulty waking in the morning, seem sleepy during the day or take naps? (P) Y N Do you feel tired a lot? (C) Y N	Do you feel sleepy a lot during the day? Y N In School? Y N While Driving? (C) Y N
3. Awakenings during the night	Does your child wake up a lot at night? (P) Y N	Does your child seem to wake up a lot at night? Y N Any sleepwalking or nightmares? (P) Y N Do you wake up a lot at night? Y N Have trouble getting back to sleep? (C) Y N	Do you wake up a lot at night? Y N Have trouble getting back to sleep? (C) Y N
4. Regularity and duration of sleep	Does your child have a regular bedtime and wake time? Y N What are they? _____	What time does your child go to bed and get up on school days? _____ _____ Weekends? _____ Do you think he/she is getting enough sleep? (P) Y N	What time do you usually go to bed on school nights? _____ Weekends? _____ How much sleep do you usually get? (C) _____
5. Snoring	Does your child snore a lot or have difficult breathing at night? Y N	Does your child have loud or nightly snoring or any breathing difficulties at night? (P) Y N	Does your teenager snore loudly or nightly? (P) Y N

(P) Parent-directed question

(C) Child-directed question

Source: “A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems” by Jodi A. Mindell and Judith A. Owens; Lippincott Williams & Wilkins



Indicate Areas of Pain
Following the Pain Scale:
1 Mild pain
2 Moderate pain
3 Severe pain

**AUTHORIZATION TO RELEASE INFORMATION TO THE BELOW
LISTED REFERRING AND TREATING HEALTH CARE
PROFESSIONALS:**

Doctors Name

Location/Phone

I authorize the release of communications regarding my treatment with _____ including a full report of examination findings, diagnosis, treatment plan, and progress reports to the providers listed above.

Signed _____ Date _____