MEDICAL AND DENTAL HISTORY

Patient Name: _____ Date of Birth: _____ Date: _____

List any hospitilizations or major operations: _____

Serious head or neck injury? Yes ☐ No ☐ Explain: _____

Have you been told to take antibiotics before dental procedures? Yes ☐ No ☐

Women: Pregnant? Yes ☐ No ☐ Due Date: _____ Nursing? Yes ☐ No ☐

MEDICATIONS: No Medications ☐

_____

_____

_____

_____

ALLERGIES: No Known Allergies ☐

Aspirin	☐	Anesthetic	☐
Codeine	☐	Penicillin	☐
Iodine	☐	Sulfa	☐
Latex	☐	Other	_____

MEDICAL HISTORY:	Yes	No		Yes	No		Yes	No
Aids/HIV	☐	☐	Blood disorder	☐	☐	Heart surgery ot disorder	☐	☐
Hepatitis type _____	☐	☐	Cancer	☐	☐	Chest pains	☐	☐
Anemia	☐	☐	Liver disease	☐	☐	Heart murmur	☐	☐
Hypoglycemia	☐	☐	Kidney problems	☐	☐	Artificial heart valve	☐	☐
Epilepsy	☐	☐	Immune disorder	☐	☐	Drug dependency	☐	☐
Glaucoma	☐	☐	Alzheimer's disease	☐	☐	Respitory disorder	☐	☐
Asthma	☐	☐	Artificial joint	☐	☐	Ulcers	☐	☐
Excessive bleeding	☐	☐	Psychiatric care	☐	☐	Cold sores	☐	☐
Diabetes	☐	☐	Acid reflux	☐	☐	Tobacco use _____	☐	☐
Heart attack/failure	☐	☐	TMJ disorder	☐	☐	Have you taken a sleep test	☐	☐
Stroke	☐	☐	Sinus trouble	☐	☐	Sleep apnea	☐	☐
High blood pressure	☐	☐	Weight gain	☐	☐	Family history of sleep apnea	☐	☐
Thyroid problems	☐	☐	Snore	☐	☐	CPAP use	☐	☐
Chronic pain	☐	☐	Others in household snore	☐	☐	Other _____		

Answer the following: 1 Never, 2 Sometimes, 3 Mostly, 4 Always

Head, neck or jaw pain	1	2	3	4	Difficulty staying asleep	1	2	3	4
Popping or clicking of jaw	1	2	3	4	Daytime tiredness	1	2	3	4
Headaches	1	2	3	4	Mornings feel great	1	2	3	4
Gasping for air	1	2	3	4	# of hours of sleep		<6		>8

Height: _____

Weight: _____

Neck Circumference

Women	<16in	>16in
Men	<17in	>17in

For office use only:

Classify

1 2 3 4

Notes: _____

Recommended Treatment

* Ripple *Ripple Plus *Home sleep test

*No Treatment *Referring to: _____

Chief Complaint: _____ Duration: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient) health. It is my responsibility to inform the dental office of any changes in medical conditions or medications.

Signature of Patient, Parent or Guardian: _____ Date: _____