# 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:
   .....
   .....
   .....
   .....
   .....
   .....
   .....
   .....

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) | Latex rubber |
| Penicillin or other antibiotics | Sedatives |
| Sulfa drugs | Barbiturates |
| Acrylics | Other (please list)_____ |
| Iodine | _____ |
| Aspirin | _____ |
| Any metals (e.g. nickel, mercury, etc.) | _____ |

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:_____