Sylvia Beeman DDS

# Medical History/Questionnaire

Please take a moment to complete the questions below so that we may appropriately address your health concerns.

**MEDICAL HISTORY – please provide all allergies, current medications and medical conditions below**

ALLERGIES _____

_____

CURRENT MEDICATIONS _____

_____

MEDICAL CONDITIONS: _____

_____

LIST ANY SPECIFIC SLEEP RELATED CONDITION(S): _____

Do you smoke or have you previously smoked/chewed tobacco? _____

Do you consume caffeine before bed? _____ Do you consume alcohol before bed? _____

Check if you have a family history of: Heart Disease _____ High Blood Pressure _____ Diabetes _____

**Have you ever had a sleep study? Y / N**

If yes, LOCATION: _____ DATE _____

**Have you ever tried CPAP? Y / N**

If yes, how many nights do you wear it? _____ If yes, how many hours per night do you wear it? _____

List any problems you have with your CPAP (if any)

_____

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**DENTAL HISTORY:**

**How would you rate your dental health?** EXCELLENT GOOD FAIR POOR

**Have you ever had teeth extracted?**

**Yes No IF YES describe** _____

**Do you wear removable partials?**

**Yes No**

**Do you wear dentures?**

**Yes No**

**Have you worn orthodontics (braces)?**

**Yes No IF YES when?** _____

**Does your TMJ (jaw joint) click or pop?**

**Yes No**

**Do you have pain in this joint?**

**Yes No IF YES describe:** _____

**Have you had TMJ (jaw joint) surgery?**

**Yes No IF YES when?** _____

**Have you ever had gum problems?**

**Yes No IF YES describe?** _____

**Have you ever had gum surgery?**

**Yes No**

**Do you have morning dry mouth?**

**Yes No**

**Have you ever had injury to your head, face, neck, mouth, or teeth?**

**Yes No IF YES describe?** _____

**Are you planning to have dental work done in the near future?**

**Yes No IF YES describe?** _____

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**CURRENT SYMPTOMS / HEALTH CONCERNS: (check all that apply)**

___ Frequent snoring
___ Excessive daytime sleepiness (EDS)
___ Difficulty falling asleep
___ Difficulty in maintaining sleep
___ Waking up gasping
___ Choking while sleeping
___ Nighttime heartburn or GERD
___ Feeling unrefreshed in the morning
___ Irritability or mood swings
___ Memory Problems
___ Snoring which affects the sleep of others
___ Others have observed that I stop breathing while I sleep
___ Morning headaches
___ Nasal problems or difficulty breathing through the nose
___ Clenching or grinding teeth at night
___ TMJ or jaw pain
___ Neck or facial pain
___ Sounds in jaw joint (clicking, popping or grating)
___ I have been told that I stop breathing when I sleep
___ Other

Rate your overall energy level 0 -10 (10 being the highest) _____

Rate your sleep quality 0-10 (10 being the highest) _____

Have you been told you snore? _____

Rate the sound of your snoring 0 -10 (10 being the highest) _____

On average how many times per night do you wake up? _____

On average how many hours of sleep do you get per night? _____

How often do you wake up with morning headaches? _____

Do you have a bed time partner? _____

If yes do they sleep in the same room? _____

How many times per night does your bedtime partner notice you quit breathing? _____

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT/GUARDIAN SIGNATURE _____ DATE: _____

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# Dental Sleep Intake Form

First Name: _____ Last Name: _____ Date of Birth _____

Home Phone (_____) _____ Cell Phone (_____) _____ Email _____

Address: _____City:_____ State: _____ Zip: _____

Diagnosed with Sleep Apnea: _____ Currently wears CPAP _____ Currently has Oral Appliance _____

Do you wear dentures or partials ? _____ Details _____

Reason for Call / Other Notes _____

Name of Facility & Date of first sleep study (if applicable) _____

Name of Facility & Date of most recent sleep study (if applicable) _____

REFERRED BY: _____

**Primary MEDICAL Insurance Information**: Patient's Relationship to Primary Insured: □ Self □ Spouse □ Child □ Other

Name of Insured (SUBSCRIBER) _____ Insured DOB _____

Insurance: _____ Medicare / Tricare / Medicare Advantage / HMO / PPO

ID # (with alpha characters): _____ Group #: _____

**Secondary MEDICAL Insurance Information**: Patient's Relationship to Primary Insured: □ Self □ Spouse □ Child □ Other

Name of Insured (SUBSCRIBER) _____ Insured DOB _____

Insurance: _____ Medicare Supp Plan? ____

ID # (with alpha characters): _____ Group #: _____

**Physicians**

PRIMARY CARE: _____ Phone/Location: _____

SLEEP SPECIALIST: _____ Phone/Location: _____

DENTIST: _____ Phone/Location: _____

OTHER MD: _____ Phone/Location: _____

DS3 PATIENT CREATED _____ LINK EMAILED TO PATIENT _____ CONSULT SCHEDULED (DATE)_____

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## Screening Questionnaire

| First Name | Last Name | Gender | Date of Birth | Age |
|---|---|---|---|---|
| | | | | |

| **Have you been diagnosed with or experienced the following conditions?** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Arrythmia (eg. Atrial fibrilation) | Yes ◯ | No ◯ | | Morning Headaches | Yes ◯ | No ◯ | | |
| Heart Disease or Heart Failure | Yes ◯ | No ◯ | | Depression or ADD | Yes ◯ | No ◯ | | |
| Stroke (year _____) | Yes ◯ | No ◯ | | Heart Attack (year _____) | Yes ◯ | No ◯ | | |
| Insomnia | Yes ◯ | No ◯ | | Fatigue | Yes ◯ | No ◯ | | |
| Sleep Apnea | Yes ◯ | No ◯ | | Irritability or moodiness | Yes ◯ | No ◯ | | |
| **Have you ever…** | | | | | | | | |
| Worn CPAP or BIPAP? | Yes ◯ | No ◯ | | If yes, are you currently wearing regularly? | Yes ◯ | No ◯ | | |
| Had a Sleep Study ? | Yes ◯ | No ◯ | | If yes, list the location & approx. date _____ | | | | |

**Epworth Sleepiness Scale:** How likely are you to doze off or fall asleep in the following situations?

| Even if you have not done these recently try to determine how they would have affected you. Using the scale on the right, fill in the appropriate circle | would never doze **0** | slight chance of dozing **1** | moderate chance of dozing **2** | high chance of dozing **3** |
|---|---|---|---|---|
| Sitting and reading | ◯ | ◯ | ◯ | ◯ |
| Watching TV | ◯ | ◯ | ◯ | ◯ |
| Sitting, inactive, in a public place (theater, meeting) | ◯ | ◯ | ◯ | ◯ |
| As a passenger in a car for an hour without a break | ◯ | ◯ | ◯ | ◯ |
| Lying down to rest in the afternoon | ◯ | ◯ | ◯ | ◯ |
| Sitting and talking to someone | ◯ | ◯ | ◯ | ◯ |
| Sitting quietly after lunch | ◯ | ◯ | ◯ | ◯ |
| In a car, while stopped for a few minutes in traffic | ◯ | ◯ | ◯ | ◯ |

| **STOP-BANG Questionnaire** | | | | | *---FOR OFFICE USE ---* | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Have you been told that you **S**nore loudly? | Yes ◯ | No ◯ | | | ***B**MI: > 35kg/m$^2$ (W: _____ H:_____; BMI _____)* | Yes ◯ | No ◯ | | |
| Do you often feel **T**ired, fatigued, or sleepy during the day? | Yes ◯ | No ◯ | | | ***A**ge: >50 years old* | Yes ◯ | No ◯ | | |
| Has anyone **O**bserved you stop breathing during your sleep? | Yes ◯ | No ◯ | | | ***N**eck Measurement: >16" (measure _____)* | Yes ◯ | No ◯ | | |
| Do you have High Blood **P**ressure? | Yes ◯ | No ◯ | | | ***G**ender: MALE* | Yes ◯ | No ◯ | | |

**PATIENT Signature:** _____

*(I understand this is only a screening & not intended to diagnosis a sleep disorder)*

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## Update Medical History

Please take a moment to notify us of any changes in your medical history, medications, insurance, and contact information if it has recently changed. By providing us with updated information, we can better communicate with you and provide you the best possible service. THANK YOU!

**Have you had any changes in your medical history (diagnosed with new conditions, surgery, tests)? Y / N**

If yes, please describe: _____

_____

**Have you had any changes in your medications? Y / N**

If yes, please describe: _____

_____

**Has your insurance changed? Y / N**

If yes, please provide the following: INSURANCE COMPANY: _____

CONTRACT NUMBER: _____

SUBSCRIBER NAME & DATE OF BIRTH: _____

**Has your contact information changed? Y / N**

If yes, please provide the following: NEW ADDRES _____

NEW PHONE NUMBER: _____ NEW EMAIL: _____

YOUR NAME & DATE: _____

SIGNATURE: _____

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