PATIENT HISTORY OF CONDITION

Today's Date: _____/20_____

Title	First Name	Last Name
❒ Mr. ❒ Mrs. ❒ Ms. ❒ Dr.		

Street Address	City / Province	Postal Code

Telephone (home)	Telephone (cellular)	Telephone (work)

Date of Birth (Month Day Year)	Who referred you to our office?
/ /	

May we contact your doctor for additional information if necessary?	❒ Yes ❒ No	Doctor's Name:	

Height	in cm	Weight	lb kg	Neck Circumference	in cm

Email address	@

Person Responsible for Account	❒ Same as above	
Title	First Name	Last Name
❒ Mr. ❒ Mrs. ❒ Ms. ❒ Dr.		

Street Address	City / Province	Postal Code

Telephone (home)	Telephone (cellular)	Telephone (work)

Please note:

The information contained in this form is confidential and will not be released without your written authorization.

What is your main concern today, what brings you to our office? Please describe as best you can.		
When did the symptoms first appear? How long have they been present?	❒ <3 months ❒ 3-6 months ❒ 6-12 months ❒ > 12 months	
Are the symptoms worsening with time?	❒ No ❒ Yes	
Are your symptoms always present?	❒ No ❒ Yes (Explain)	
What treatment(s) have you had to date?		Month Year
		Month Year
		Month Year
		Month Year
		Month Year
Did any of these treatments help? Please explain.	❒ No ❒ Yes	

Do you experience headaches?	❒ No ❒ Yes When? ❒ on waking ❒ mid-day ❒ in the evening ❒ at night ❒ all day long
Where do they occur?	❒ over the eyes ❒ forehead ❒ temples ❒ side of head ❒ base of skull ❒neck
Do they occur on one or both sides?	❒ left side ❒ right side ❒ both sides
Are your headaches preceded by an aura?	❒ No ❒ Yes
Do your headaches spread to other areas?	❒ No ❒ Yes
How often do you have headaches?	❒ Never ❒ daily ❒ weekly ❒ monthly

Please list all medications/drugs including herbal and recreation that you are currently using. If you have a printout from your pharmacy please let us know so that we may make a copy for your file. Please list each on a separate line. Use the reverse of this page if you require more room.		

Please list any medical conditions you have been medically diagnosed with or are under treatment for.	
Do you have a family history of stroke or brain aneurisms?	❒ No ❒ Yes
Are you currently taking an **SSRI/SSNRI type** antidepressant medication? (Celexa, Lexapro, Prozac, Paxil, Pexeva, Zoloft, Vilazodone etc.)	❒ No ❒ Yes Which One?
	Other antidepressant? Which One?
	How long have you been taking this medication?
Have you had your tonsils/adenoids removed	❒ No ❒ Yes At what age were you when they were removed?
Do you breathe through your mouth	❒ No ❒ Yes, when awake ❒ Yes, when asleep ❒ Yes, all of the time
Have you been told you snore?	❒ No ❒ Yes
Do you ever wake gasping or choking?	❒ No ❒ Yes
Has your bed partner ever told you that you stop breathing in the night?	❒ No ❒ Yes
Have you ever had an overnight sleep study conducted in a sleep lab?	❒ No ❒ Yes If yes, when and where?
Haw you been diagnosed with sleep apnea or UARS (upper airway resistance syndrome?	❒ No ❒ Yes

Men: *what is the chance of you dozing off when you are?* **Women**: *what is the chance of you feeling sleepy when you are?*

	No Chance	Slight Chance	Moderate Chance	High Chance
Sitting and reading a book?	❒	❒	❒	❒
Watching TV?	❒	❒	❒	❒
Sitting in a public place (theatre, meeting etc.)	❒	❒	❒	❒
As a passenger in a car for an hour without a break?	❒	❒	❒	❒
Lying down in the afternoon when circumstances permit?	❒	❒	❒	❒
Sitting quietly after lunch without alcohol?	❒	❒	❒	❒
In a car, when stopped for a few minutes in traffic?	❒	❒	❒	❒
			Total:	

How often do you chew gum?	❒ Never ❒ Daily ❒ Weekly ❒ Monthly
Do you have pain in your jaw joints when opening wide or chewing?	❒ No pain ❒ Left side ❒ Right side ❒ Both sides
Does you jaw click or pop when opening or closing?	❒ No ❒ Yes ❒ Left side ❒ Right side ❒ Both sides
Has your jaw ever locked wide open where you could not close?	❒ No ❒ Yes ❒ Left Side ❒ Right Side ❒ Both sides
Has your jaw ever locked closed where you could not open?	❒ No ❒ Yes ❒ Left side ❒ Right side ❒ Both sides
Do you experience pain in your neck?	❒ No ❒ Yes ❒ Left side ❒ Right side ❒ Both sides
Do you experience pain in your shoulders?	❒ No ❒ Yes ❒ Left side ❒ Right side ❒ Both sides
Are your teeth sensitive to hot, cold or sweet?	❒ No ❒ Yes ❒ Upper Left ❒ Upper Front ❒ Upper Right ❒ Lower Left ❒ Lower Front ❒ Lower Right
Do you teeth ache without reason?	❒ No ❒ Yes
Are you prone to sinus infections?	❒ No ❒ Yes

Are you being treated for periodontal (gum) disease or have loose teeth?	❒ No ❒ Yes Explain:

Have you been involved in any accidents? Please indicate what kind of accident i.e. car, fall, etc. and approximately when it occurred.	❒ No ❒ Yes	*Month*	*Year*
Were you ever knocked unconscious?	❒ No ❒ Yes For how long? Minutes		

Additional Information:

(Please add any additional information you feel would be helpful)

Consent for Examination:

I, _____, consent to this examination today, including radiographs, if needed. I also consent the contacting of my dentist, my family doctor and any specialists treating me for additional information, if needed. I consent to the sending of a written report of today's examination to the referring doctor. I understand that although most dental plans cover this examination, I am responsible for any fees not covered by my dental plan. All the information listed is accurate and I am not withholding any information,

_____ _____
Patient's Signature Date

_____ _____
Reviewer's Signature Date

Thank you for completing this questionnaire. We will review this with you shortly and add additional information as necessary.

This information is confidential and <u>will not be released to any third parties</u> other than listed above (including insurance companies) without your written consent.