Dental History

Patient's Name_____ Birth date _____

What is the reason for your visit today?

_____

Do you have any dental problems that you are aware of? _____ If yes, please describe

_____

Date of last dental visit _____

Do you feel nervous about having dental treatment? _____ If yes, what is your biggest concern?

_____

Are your teeth sensitive? _____ Do you suffer from TMJ pain, headaches, or migraines? _____

Do you catch food between your teeth? _____ Do you grind your teeth? _____

Is there anything you would like to change about your smile? _____

Have you ever worn braces? _____ If so, when? _____ Do you wear a retainer?_____

Is bad breath a concern? _____ Do your gums bleed? _____

Have you noticed your gums receding?_____

Have you ever whitened your teeth? _____If so, where you happy with the result?_____

If not, are you interested in more information about teeth whitening? _____

Do you drink coffee tea soda? If so, how often and how much? _____

Is there anything else about having dental treatment you would like us to know? _____

If yes, please describe _____

Are you at risk for Sleep Apnea?

Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?

Yes No

Do you often feel TIRED, fatigued, or sleepy during daytime?

Yes No

Has anyone OBSERVED you stop breathing during your sleep?

Yes No

Do you have or are you being treated for high blood PRESSURE?

Yes No

Is your BMI more than 35kg/m2?

Yes No

AGE over 50 years old?

Yes No

NECK circumference > 17 inches (43cm) male or 16 inches (41cm) female?

Yes No

GENDER: Male?

Yes No

TOTAL SCORE

High risk of OSA: Yes 5 - 8 Intermediate risk of OSA: Yes 3 - 4 Low risk of OSA: Yes 0 - 2