Medical History Update Today's Date: _____

Name: _____ Date of Birth: _____
Height: _____Weight: _____BMI: _____Blood Pressure: _____Neck Size (Inches): _____
Current Physician (Primary Care/Family Doctor/Internal Medicine): _____
Location: _____ _____Phone Number: _____
Other Treating Physician(s): _____

Airway Management

Please check any of the following you may have (or suffer from):

☐ Morning Headaches	☐ Heart Disease	☐ Insomnia	☐ Diabetes	☐ Heart Failure
☐ Frequent Urination at Night	☐ ADD/ADHD	☐ Depression	☐ Dry Mouth	☐ Renal Failure
☐ Sexual Dysfunction	☐ Fibromyalgia	☐ Obesity	☐ Memory Loss	☐ Low Testosterone
☐ Grinding Teeth (Bruxism)	☐ Restless Legs (RLS)	☐ COPD	☐ GERD	☐ Atrial Fibrillation
☐ Fatigue/Hypersomnia	☐ Jaw Discomfort	☐ Hypertension	☐ Snoring	

Please check Yes or No to the following questions:

1. Do you snore *or* have been told that you snore?	☐ YES	☐ NO
2. Do you often feel tired, fatigued, or sleepy during the daytime?	☐ YES	☐ NO
3. Has anyone observed you stop breathing or gasp for air during your sleep?	☐ YES	☐ NO
4. Do you have or are you being treated for high blood pressure?	☐ YES	☐ NO

Please check the following appropriate boxes:

Epworth Sleepiness Scale	Never doze off	Slight chance of dozing	Moderate chance of dozing	High Chance of dozing
1. Do you get sleepy, or doze off, while sitting and reading?	0 ☐	1 ☐	2 ☐	3 ☐
2. Do you get sleepy, or doze off, while watching TV?	0 ☐	1 ☐	2 ☐	3 ☐
3. While sitting or inactive in a public place?	0 ☐	1 ☐	2 ☐	3 ☐
4. As a passenger in a car for an hour without a break?	0 ☐	1 ☐	2 ☐	3 ☐
5. Lying down to rest in the afternoon?	0 ☐	1 ☐	2 ☐	3 ☐
6. Sitting and talking to someone?	0 ☐	1 ☐	2 ☐	3 ☐
7. Sitting quietly after lunch without alcohol?	0 ☐	1 ☐	2 ☐	3 ☐
8. In a car, while stopped for a few minutes at a traffic light?	0 ☐	1 ☐	2 ☐	3 ☐
			Total Score	

Have you ever been diagnosed with sleep apnea?	☐ YES	☐ NO
Are you currently using CPAP? (or any other apnea/snoring device)	☐ YES	☐ NO
Are you currently taking any sleeping aids (prescribed or OTC)?	☐ YES	☐ NO
Are you currently taking any prescribed pain medication?	☐ YES	☐ NO

Oral Cancer

Please check the following appropriate boxes

1. Have you ever been diagnosed or have a family history of Oral Cancer?	☐ YES	☐ NO
2. Have you ever been diagnosed or have a family history **HPV**?	☐ YES	☐ NO
3. Do you currently use any tobacco products, or have used them in the past?	☐ YES	☐ NO
4. Do you use e-cigarettes or do you use vapor devices?	☐ YES	☐ NO
5. Do you regularly consume alcoholic beverages?	☐ YES	☐ NO