ADULT HEALTH HISTORY FORM

Today's Date: _____/_____/_____

CHRISTENSEN ORTHODONTICS
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ADULT PATIENT

Name:_____
Last First
Male: _____ Female: _____
Mailing Address: _____
City:_____ State:_____Zip:_____
How long at this address?: _____
Date of Birth: _____/_____/_____ Age: _____
Social Security Number: _____/_____/_____
Home Phone: _____/_____/_____
Cell Phone: _____/_____/_____
Email: _____
Employer: _____
How long with this employer: _____

SPOUSE

Name:_____
Last First
Male: _____ Female: _____
Mailing Address: _____
City:_____ State:_____Zip:_____
How long at this address?: _____
Date of Birth: _____/_____/_____ Age: _____
Social Security Number: _____/_____/_____
Home Phone: _____/_____/_____
Cell Phone: _____/_____/_____
Email: _____
Employer: _____
How long with this employer: _____

☐ **PLEASE CHECK IF THERE IS NO INSURANCE**

☐ Check if insurance is the same ☐ Check if insurance benefits have changed

PRIMARY DENTAL INSURANCE

Insured Name: _____
Relationship to patient: _____
Insured Date of birth: _____/_____/_____
Social Security Number:_____/_____/_____
Employer:_____
Group #: _____ ID#: _____
Insurance Company: _____
Ins. Phone Number: _____

PRIMARY MEDICAL INSURANCE

Insured Name: _____
Relationship to patient: _____
Insured Date of birth: _____/_____/_____
Social Security Number: _____/_____/_____
Employer:_____
Group #: _____ ID#: _____
Insurance Company: _____
Ins. Phone Number: _____

Who may we thank for referring you to our office?

_____

In the event of an emergency, who should we contact?

Name: _____
Relationship: _____ Phone #: _____/_____/_____

****PLEASE COMPLETE BOTH SIDES****

DENTAL HISTORY *CONFIDENTIAL*

Current Dentist: _____ Last Visit: _____

Do you like your smile? ____Yes _____No

Have you ever been evaluated for orthodontics? ____Yes _____No

Your current dental health is: ____Good _____Fair _____ Poor

Do you brush and floss daily? ____Yes _____No

Have you ever had injury to your face/mouth? ____Yes _____No

Do you or have you ever experienced pain/discomfort in your jaw? ____Yes _____No

MEDICAL HISTORY

Primary Care Physician (PCP):_____ Facility:_____ Phone:_____

Are you currently under the care of a physician? ____Yes _____No

Please explain_____

Are taking any prescriptions/over-the-counter drugs? ____Yes _____No

Please list any/all:_____

Do you use tobacco of any form? ____Yes _____No

Have you had a Sleep Study done? ____Yes _____No If yes, where? _____

FOR WOMEN: Are you pregnant? ____Yes _____No Weeks:_____

Have you ever had any of the following:

___Abnormal Bleeding
___AIDS/HIV+
___Anemia/Radiation
___Artificial bones/joints
___Asthma
___Arthritis
___Blood transfusion
___Cancer/Chemo
___Congenital Heart Defect
___Diabetes
___Sleep Apnea
___Difficulty breathing
___Epilepsy/Convulsions
___Fainting
___Hearing Impairment
___Heart attack/stroke
___Heart Murmur
___Hepatitis
___Heart Surgery
___High Blood Pressure
___Low Blood Pressure
___Hospital Stay/operations
___Kidney Problems
___Liver Problems
___Lupus
___Measles
___Mitral valve Prolapse
___Rheumatic Fever
___Scarlet Fever
___Severe/Frequent headaches
___Tuburculosis(TB)

Please list any other serious medical conditions/problems you may have: _____

_____

Are you allergic to any of the following?: ___Codeine ___Penicillin ___Sulfa ___Anesthetics
___Metals/Plastics ___Latex

Please list any other drugs/materials that you are allergic to: _____

By signing below, I acknowledge that I have read and received the Notice of Privacy Practives, as mandated by the Heath Insurance Portability and Accountability Act of 1996 ('HIPPA')

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this office of any changes in my medical status. I also authorize this office to perform necessary dental services I may need.

Signature of patient _____ Date _____/_____/_____

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name	
Weight	Pounds	**Age**	Years	Gender Male ○ Female ○
Height	Feet	Inches	**Neck Size**	Inches
Date of Birth	Month / Day / Year		**ID Number**	Optional

Tally ARES Risk Points

Neck Size
+2 Male ≥16.5
+2 Female≥15.0

Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score **TOTAL** the values from all 8 questions,
If 11 or less **Score = 0**
If 12 or more **Score = 2**

Score

Frequency **0 - 1 times/week** **1 - 2 times/week** **3 - 4 times/week** **5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Assign points for each of the first three responses

Signature	Area Code / Phone Number	Total all 6 boxes from above If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	Point Total

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ADULT SLEEP, BREATHING & HABIT ASSESSMENT

Today's Date _____/_____/_____

Patient's Name _____ Birthday _____/_____/_____ Age_____

Medical issues: _____ Medications taking: _____

Previous clip or release of tongue? _____ (Date)_____

Sleep History:

Lights out: _____ AM / PM
Lights on: _____ AM / PM
Number of awakenings during the night _____

Trips to the bathroom at night? _____
Do you taken any sleep aids? Y / N
If yes, which ones? _____

Have you experienced any of the following issues? Please check or elaborate as needed.

Speech:

___ Frustration with communication
___ Difficult to understand by others
___ Difficulty speaking fast
___ Difficulty getting words out (groping for words)
___ Trouble with sounds (which?)_____
___ Speech delay (when?)_____
___ Stuttering
___ Speech harder to understand in long sentences
___ Speech therapy (how long)_____
___ Mumbling or speaking softly
___"Baby Talk"

Feeding:

___ Frustration when eating
___ Slow Eater (don't finish meals)
___ Graze on food throughout the day
___ Packing food in cheeks like a chipmunk
___ Picky with textures
___ Chocking or gagging on food
___ Spits out food
___ Other:

Sleep Issues (Check all that apply)

___ Difficulty Falling Asleep
___ Difficulty Staying Asleep
___ Snoring
___ Witnessed Apneas
___ Gasping/Choking during sleep
___ Sweating/perspiring during sleep
___ Sleeps in strange positions
___ Moves around a lot at night (kicks)
___ Wakes easily or often
___ Grinds teeth while sleeping
___ Sleeps with mouth open
___ Dry mouth upon awakening
___ Teeth grinding/clenching
___ Talking in your sleep
___ Heart Palpitations

___ Ischemic Heart Disease
___ Cardiac Arrhythmia's
___ Tired/Fatigue during the day
___ Excessive Daytime sleepiness
___ Nasal allergies/congestion
___ Asthma
___ Pulmonary Hypertension
___ Depressed mood/irritability
___ Mood Disorders
___ Anxiety/Stress
___ Difficulty with concentration
___ Cognition Impaired
___ Chest pain/chest discomfort
___ Shortness of breath during the day
___ Acting out dreams

Other related issues:

___ Neck or shoulder pain or tension
___ TMJ Pain, clicking, or popping
___ Headaches or migraines
___ Strong gag reflex
___ Mouth open /mouth breathing during the day
___ Tonsils or adenoids removed previously

___ Ear tubes previously
___ Reflux (medicated or not)
___ Hyperactivity / Inattention
___ Constipation