Dr. Jeremy Chatfield DDS 8152 N Wayne Blvd, Hayden, Idaho 83835 (208) 500-3030

Patient Information: Comprehensive Health Questionnaire

Full Name:

DOB: Age: Height: ft. in. Weight: lbs.

Referred By:

Do you currently experience any of the following symptoms?

Number your top 5 symptoms 1 through 5

_____ Headache (inside your head)	☐ Recent	☐ Chronic		_____ Dizziness	☐ Recent	☐ Chronic	
_____ Headache (outside your head)	☐ Recent	☐ Chronic		_____ Ringing in Ears (Tinnitis)	☐ Recent	☐ Chronic	
_____ Jaw Pain	☐ Recent	☐ Chronic		_____ Vision Problems	☐ Recent	☐ Chronic	
_____ Chewing Pain	☐ Recent	☐ Chronic		_____ Muscle Spasm	☐ Recent	☐ Chronic	
_____ Face Pain	☐ Recent	☐ Chronic		_____ Sinus Congestion	☐ Recent	☐ Chronic	
_____ Eye Pain	☐ Recent	☐ Chronic		_____ Kicking or jerking leg repeatedly	☐ Recent	☐ Chronic	
_____ Throat Pain	☐ Recent	☐ Chronic		_____ Numbness (Localized)	☐ Recent	☐ Chronic	
_____ Neck Pain	☐ Recent	☐ Chronic		_____ Nerve Pain	☐ Recent	☐ Chronic	
_____ Shoulder Pain	☐ Recent	☐ Chronic		_____ Dental Changes	☐ Recent	☐ Chronic	
_____ Back Pain	☐ Recent	☐ Chronic		_____ Teeth Spacing	☐ Recent	☐ Chronic	
_____ Difficulty Opening Mouth	☐ Recent	☐ Chronic		_____ Teeth Sensitivity	☐ Recent	☐ Chronic	
_____ Difficulty Closing Mouth	☐ Recent	☐ Chronic		_____ Changes with your Bite	☐ Recent	☐ Chronic	
_____ Noises in Jaw Joints	☐ Recent	☐ Chronic		_____ Morning Hoarseness	☐ Recent	☐ Chronic	
_____ Ear Stuffiness	☐ Recent	☐ Chronic		_____ Dry Mouth Upon Waking	☐ Recent	☐ Chronic	
_____ Fatigue	☐ Recent	☐ Chronic		_____ Unable to Tolerate C-Pap	☐ Recent	☐ Chronic	
_____ Tossing and Turning Frequently	☐ Recent	☐ Chronic		_____ Night Sweats	☐ Recent	☐ Chronic	
_____ Morning Headaches	☐ Recent	☐ Chronic		_____ Vivid Dreams	☐ Recent	☐ Chronic	

_____ Any Other Symptoms not listed above _____

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Allergic Reactions

Please check any and all medications or substance that have caused an allergic reaction

- ☐ Anesthetics
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Medication
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Metals
- ☐ Plastics
- ☐ Penicillin
- ☐ Sedatives
- ☐ Sulfa
- ☐ Food Allergies/Sensitivities _____

Current Medications

Please list all medications and supplements (over-the-counter and prescription) you are taking and the reason you take them.

Medication	Dosage	Reason For Taking

Previous Treatment, Medications and Other Therapies Attempted For The Condition We Are Evaluating

Treatment/Med/Therapy	Doctor/Provider	Approx. Date of Tx	Helpful (y/n)

☐ See Attached List

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Sleep Conditions

Please select the yes or no answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Position? ☐ Side ☐ Back ☐ Stomach ☐ Varies

Sleep Location? ☐ Bed ☐ Couch ☐ Chair ☐ Other

Bed Partner? ☐ Yes ☐ No

Average hours of sleep per night? _____

Is it easy to fall asleep? ☐ Yes ☐ No

Average hours of sleep per day? _____

Do you wake often during the night? ☐ Yes ☐ No

Cough, gasps or snorts on waking? ☐ Yes ☐ No

Do you feel rested upon waking? ☐ Yes ☐ No

Observed pauses in breath? ☐ Yes ☐ No

Stopped breathing during sleep? ☐ Yes ☐ No

Have you ever had a sleep test?: ☐ HST ☐ PSG ☐ No Date: _____ Result: _____

Previous positive airway pressure devices used? ☐ CPAP ☐ BiPAP ☐ ASV ☐ APAP

Do you currently use a PAP Device? ☐ Yes ☐ No Type: _____

Previous Oral Appliance? ☐ Yes ☐ No Type: _____

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Health And Medical History

Are you currently pregnant?	☐ Yes	☐ No	How many energy drinks do you drink? _____ /day
Do you drink 4 or more cups of coffee per day?	☐ Yes	☐ No	
Do you smoke tobacco?	☐ Yes	☐ No	
Do you consume alcohol or take sedatives?	☐ Yes	☐ No	
Do you have trouble breathing through your nose?	☐ Yes	☐ No	
Have you had prior orthodontic treatments?	☐ Yes	☐ No	
Have you had previous injury to:	☐ Head	☐ Neck	☐ Face ☐ Teeth ☐ Other

Surgical History

Have you had any of the following:

General Anesthesia	☐ Yes	☐ No	Orthognathic Surgery	☐ Yes	☐ No
Adenoids Removed	☐ Yes	☐ No	Oral Surgery	☐ Yes	☐ No
Tonsils Removed	☐ Yes	☐ No	Removal of Third Molar (Wisdom Teeth)	☐ Yes	☐ No

Other surgeries: _____

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Additional Health And Medical History

Do you have or have you experienced any of the following

Anemia	☐ Yes	☐ No	☐ Fam Hx
Anxiety	☐ Yes	☐ No	☐ Fam Hx
Asthma	☐ Yes	☐ No	☐ Fam Hx
Bleeding Easily	☐ Yes	☐ No	☐ Fam Hx
Birth Defects	☐ Yes	☐ No	☐ Fam Hx
Bruising Easily	☐ Yes	☐ No	☐ Fam Hx
Cancer of _____	☐ Yes	☐ No	☐ Fam Hx
Chemo	☐ Yes	☐ No	☐ Fam Hx
Chronic Fatigue	☐ Yes	☐ No	☐ Fam Hx
Cold Hands and Feet	☐ Yes	☐ No	☐ Fam Hx
Fainting	☐ Yes	☐ No	☐ Fam Hx
Frequent Colds/Flu	☐ Yes	☐ No	☐ Fam Hx
Frequent Cough	☐ Yes	☐ No	☐ Fam Hx
Frequent Ear Infections	☐ Yes	☐ No	☐ Fam Hx
Frequent Sore Throat	☐ Yes	☐ No	☐ Fam Hx
Awakening from Sleep_____x	☐ Yes	☐ No	☐ Fam Hx
Acid Reflux	☐ Yes	☐ No	☐ Fam Hx
Glaucoma	☐ Yes	☐ No	☐ Fam Hx
Hay Fever	☐ Yes	☐ No	☐ Fam Hx
Hearing Impairment	☐ Yes	☐ No	☐ Fam Hx
Heart Attack	☐ Yes	☐ No	☐ Fam Hx
Heart Disease	☐ Yes	☐ No	☐ Fam Hx
Heart Murmur	☐ Yes	☐ No	☐ Fam Hx

Fibromyalgia	☐ Yes	☐ No	☐ Fam Hx
Fluid Retention	☐ Yes	☐ No	☐ Fam Hx
COPD	☐ Yes	☐ No	☐ Fam Hx
Depression	☐ Yes	☐ No	☐ Fam Hx
Diabetes	☐ Yes	☐ No	☐ Fam Hx
Difficulty Concentrating	☐ Yes	☐ No	☐ Fam Hx
Dizziness	☐ Yes	☐ No	☐ Fam Hx
Emphysema	☐ Yes	☐ No	☐ Fam Hx
Epilepsy	☐ Yes	☐ No	☐ Fam Hx
Excessive Thirst	☐ Yes	☐ No	☐ Fam Hx
Mitral Valve Prolaps	☐ Yes	☐ No	☐ Fam Hx
Multiple Sclerosis	☐ Yes	☐ No	☐ Fam Hx
Muscle Aches	☐ Yes	☐ No	☐ Fam Hx
Muscle Fatigue	☐ Yes	☐ No	☐ Fam Hx
Muscle Spasms	☐ Yes	☐ No	☐ Fam Hx
Muscular Dystrophy	☐ Yes	☐ No	☐ Fam Hx
Neuralgia	☐ Yes	☐ No	☐ Fam Hx
Nervous system Disorder	☐ Yes	☐ No	☐ Fam Hx
Osteoarthritis	☐ Yes	☐ No	☐ Fam Hx
Osteoporosis	☐ Yes	☐ No	☐ Fam Hx
Ovarian Cyst	☐ Yes	☐ No	☐ Fam Hx
Parkinson's Disease	☐ Yes	☐ No	☐ Fam Hx

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Heart Pacemaker	☐ Yes	☐ No	☐ Fam Hx	Poor Circulation	☐ Yes	☐ No	☐ Fam Hx
Heart Palpitations	☐ Yes	☐ No	☐ Fam Hx	Mental Health Counseling	☐ Yes	☐ No	☐ Fam Hx
Heart Valve Replacement	☐ Yes	☐ No	☐ Fam Hx	Radiation	☐ Yes	☐ No	☐ Fam Hx
Hemophilia	☐ Yes	☐ No	☐ Fam Hx	Recent Weight Gain	☐ Yes	☐ No	☐ Fam Hx
Hepatitis	☐ Yes	☐ No	☐ Fam Hx	Recent Weight Loss	☐ Yes	☐ No	☐ Fam Hx
High Blood Pressure	☐ Yes	☐ No	☐ Fam Hx	Rheumatic Fever	☐ Yes	☐ No	☐ Fam Hx
History of Substance Abuse	☐ Yes	☐ No	☐ Fam Hx	Rheumatoid Arthritis	☐ Yes	☐ No	☐ Fam Hx
Huntington's Disease	☐ Yes	☐ No	☐ Fam Hx	Scarlet Fever	☐ Yes	☐ No	☐ Fam Hx
Hypoglycemia	☐ Yes	☐ No	☐ Fam Hx	Shortness of Breath	☐ Yes	☐ No	☐ Fam Hx
Insomnia	☐ Yes	☐ No	☐ Fam Hx	Skin Disorder	☐ Yes	☐ No	☐ Fam Hx
Intestinal Disorder	☐ Yes	☐ No	☐ Fam Hx	Sinus Problems	☐ Yes	☐ No	☐ Fam Hx
Irregular Heartbeat	☐ Yes	☐ No	☐ Fam Hx	Slow Healing Sores	☐ Yes	☐ No	☐ Fam Hx
Kidney Disease	☐ Yes	☐ No	☐ Fam Hx	Speech Difficulties	☐ Yes	☐ No	☐ Fam Hx
Leukemia	☐ Yes	☐ No	☐ Fam Hx	Stroke	☐ Yes	☐ No	☐ Fam Hx
Liver Disease	☐ Yes	☐ No	☐ Fam Hx	Swollen or Painful Joints	☐ Yes	☐ No	☐ Fam Hx
Low Blood Pressure	☐ Yes	☐ No	☐ Fam Hx	Thyroid Disease	☐ Yes	☐ No	☐ Fam Hx
Meniere's Disease	☐ Yes	☐ No	☐ Fam Hx	Tuberculosis	☐ Yes	☐ No	☐ Fam Hx
Memory Loss	☐ Yes	☐ No	☐ Fam Hx	Urinary Tract Disorder	☐ Yes	☐ No	☐ Fam Hx
Migraines	☐ Yes	☐ No	☐ Fam Hx				

Additional Symptoms

Jaw Pain

Jaw pain with opening ☐ L ☐ R

Jaw pain when chewing ☐ L ☐ R

Jaw pain at rest ☐ L ☐ R

Jaw Joint Sounds

Jaw sounds with opening ☐ L ☐ R

Jaw sounds when chewing ☐ L ☐ R

Jaw Locking

Jaw locks closed ☐ Yes ☐ No

Jaw locks open ☐ Yes ☐ No

Jaw Joint Symptoms

Teeth clenching ☐ Yes ☐ No ☐ Day ☐ Night

Teeth grinding ☐ Yes ☐ No ☐ Day ☐ Night

History of Symptoms

On what date, or approximate date, did the condition you are seeking treatment for occur? _____

Are the conditions listed as the reason for visit caused by a motor vehicle accident? ☐ Yes ☐ No

If yes, what conditions: _____ Date of accident: _____

Does any family member snore or have sleep apnea? ☐ Yes ☐ No If yes, explain: _____

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Even if your symptoms are pain related please - Complete this section

1. Daytime Sleepiness Evlauation - Epworth Sleepiness Scale

For the following situations, answer with one of the following numbers:
0 - would never doze 1 - slight chance of dozing 2 - moderate chance of dozing 3 - high chance of dozing

Situation	Score	Situation	
Sitting and reading	_____	Sitting and talking to someone	_____
Watching Television	_____	Sitting quietly after a lunch (no alcohol)	_____
Sitting, inactive public place	_____	In a car, while stopped for a few minutes in traffic	_____
As a passenger in a car for an hour without a break		Lying down to rest in the afternoon when circumstances permit	_____

2. Nighttime Sleepiness Evaluation **Add Your Score** _____

Developed by David White, M.D., Harvard Medical School, Boston, MA

Score

1. Snoring

a) Do you snore on most nights (>3 nights per week)? _____

Yes (2) No (0)

b) Is your snoring loud? Can it be heard through a door or wall?

Yes (2) No (0)

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0) Occasionally (3) Frequently (5)

3. What is your collar size?

Male: Less than 17 inches (0) More than 17 inches (5) _____

Female: Less than 16 inches (0) More than 16 inches (5)

4. Do you occasionally fall asleep during the day when:

a) You are busy or active _____

Yes (2) No (0)

b) You are driving or stopped at a light?

Yes (2) No (0)

5. Have you had or are you being treated for high blood pressure? _____

Yes (2) No (0)

Add Lines 1 -5

Patient/ Guardian Signature: _____ Date: _____

(This signature represents my completing pages 1-5)