SoCal Sleep Dentistry
Adult Health History Questionnaire

Patient Name: ___________________________________ DOB: _____________ Age: __________

Sex (Circle): Male / Female Height: __________ Weight: ___________

Phone Number: _________________________________ Alternate #:________________________

Physician Name: _________________________________ Date of Last Physical: ________________

Do you have or have you had any of the following? Please check:

☐Yes ☐No Allergies? (Food, medications, latex, seasonal) What happens?
____

☐Yes ☐No Medications? (Prescriptions, inhalers, over-the-counter, vitamins)
____

☐Yes ☐No Previous surgery or anesthesia?
____

☐Yes ☐No Previous ER visit or hospitalization? When and why?
____

☐Yes ☐No Medical specialists? Cardiology / Neurology / Pulmonology / Gastroenterology
Endocrinology / Hematology / Psychiatry / Other ________________________

☐Yes ☐No Special medical tests for any reason? __________________________________

☐Yes ☐No Cold, cough, flu in the last 6 weeks? When? ______________________________

☐Yes ☐No Family history of malignant hyperthermia or problems with anesthesia?

☐Yes ☐No Do you smoke? How many packs per day? _______ How many years? _________

☐Yes ☐No Do you drink alcohol? How many drinks per week?_________________________

☐Yes ☐No Do you use recreational drugs? Please list: _________________________________

☐Yes ☐No (Women) Are you pregnant or nursing?___________________________________

Do you have or have you had any of the following? Please check the box or circle if YES:

☐Asthma, Wheezing, Shortness of Breath
☐Bronchitis, Pneumonia, Chronic Cough
☐COPD
☐Sinus Problems
☐Sleep Apnea or Snoring
☐High Blood Pressure
☐Chest Pain / Coronary Artery Disease
☐Heart Attack / Congestive Heart Failure
☐Valvular Disease / Artificial Heart Valve
☐Congenital Heart Defect or Repair
☐Innocent Heart Murmur
☐Irregular Heart Beat, Arrhythmia, Pacemaker
☐Fainting Spells or Blackouts
☐High Cholesterol or Hyperlipidemia
☐Prophylactic antibiotics before dental work
☐TMJ Problems / Limited Mouth Opening
☐Difficulty Swallowing / Aspiration
☐Acid Reflux / GERD / Hiatal Hernia
☐Stomach or Intestinal Problems

☐Diabetes (Type 1 or Type 2)
☐Liver Problems
☐Kidney Problems
☐Thyroid or other Endocrine Problems
☐Stroke / TIA or "Mini-stroke"
☐Frequent Headaches
☐Seizures / Epilepsy
☐Head or Neck or Spinal Cord Injury
☐Muscle Disorders (e.g. Muscular Dystrophy)
☐Arthritis / Rheumatoid Arthritis
☐Anxiety / Depression / Psych treatment
☐Anemia / Sickle Cell Disease / Thalassemia
☐Excessive Bleeding or Clotting Problems
☐Frequent Nose Bleeds
☐Cancer, Chemotherapy, Radiation Therapy
☐Infections (TB, HIV, Hepatitis)
☐Autoimmune Disorder
☐Other
____

Name: ________________________ Signature: ________________________ Date: ________________