SOUTH LA
Dental Sleep Medicine
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AMERICAN ACADEMY OF DENTAL SLEEP MEDICINE®
DENTAL SLEEP MEDICINE
Accredited Facility

HEALTH HISTORY

FIRST NAME	LAST NAME	D.O.B.

HAVE YOU EVER HAD AN OVERNIGHT SLEEP TEST? ☐YES ☐NO	IF YES, WHO WAS THE ORDERING PHYSICIAN?	LOCATION OF TEST	DATE OF TEST

ARE YOU ALLERGIC TO LATEX? ☐YES ☐NO	DO YOU TAKE MEDICATIONS FOR ANY OF THE FOLLOWING? ☐BLOOD PRESSURE ☐ANXIETY ☐ANTIDEPRESSANTS ☐SLEEPING PILLS	DO YOU WEAR DENTURES? ☐YES ☐NO

LIST ANY OTHER ALLERGIES:

LIST ANY OTHER MEDICATIONS:

FAMILY HISTORY

HAVE ANY BLOOD RELATIVES BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING?
☐HEART DISEASE ☐HIGH BLOOD PRESSURE ☐DIABETES ☐MOOD DISORDER ☐SLEEP DISORDER

SOCIAL HISTORY

ALCOHOL CONSUMPTION: HOW OFTEN DO YOU CONSUME ALCOHOL WITHIN 2-3 HOURS OF BEDTIME?
☐NEVER ☐OCCASIONALLY ☐2-3 TIMES PER WEEK ☐DAILY

SEDATIVE CONSUMPTION: HOW OFTEN DO YOU TAKE SEDATIVES WITHIN 2-3 HOURS OF BEDTIME?
☐NEVER ☐OCCASIONALLY ☐2-3 TIMES PER WEEK ☐DAILY

CAFFEINE CONSUMPTION: HOW OFTEN DO YOU CONSUME CAFFEINE WITHIN 2-3 HOURS OF BEDTIME?
☐NEVER ☐OCCASIONALLY ☐2-3 TIMES PER WEEK ☐DAILY

MEDICAL HISTORY

MARK EACH OF THE FOLLOWING:

	YES	NO		YES	NO		YES	NO
DIABETES I II	☐	☐	HEART DISEASE	☐	☐	HEMOPHILIA	☐	☐
HIGH BLOOD PRESSURE	☐	☐	ANGINA ARTERIOSCLEROSIS	☐	☐	AIDS OR HIV	☐	☐
LOW BLOOD PRESSURE	☐	☐	CONGESTIVE HEART FAILURE	☐	☐	AUTOIMMUNE DISEASE	☐	☐
MOOD DISORDER	☐	☐	DAMAGED HEART VALVES	☐	☐	RHEUMATOID ARTHRITIS	☐	☐
LIVER DISEASE	☐	☐	HEART ATTACK	☐	☐	LUPUS	☐	☐
EPILEPSY	☐	☐	HEART MURMUR	☐	☐	ASTHMA	☐	☐
NEUROLOGICAL DISORDERS	☐	☐	THYROID PROBLEMS	☐	☐	BROCHITIS	☐	☐
INSOMNIA	☐	☐	ACID REFLUX/HEARTBURN	☐	☐	EMPHYSEMA	☐	☐
FATIGUE	☐	☐	CONGENITAL HEART DEFECT	☐	☐	SINUS TROUBLE	☐	☐
BRAIN FOG	☐	☐	MITRAL VALVE PROLAPSE	☐	☐	TUBERCULOSIS	☐	☐
MENTAL HEALTH DISORDER	☐	☐	PACEMAKER	☐	☐	CANCER	☐	☐
MEMORY LOSS	☐	☐	RHEUMATIC FEVER	☐	☐	CHRONIC PAIN	☐	☐
HEADACHES/MIGRAINES	☐	☐	STROKE	☐	☐	EXCESSIVE URINATION	☐	☐
DIFFICULTY CONCENTRATING	☐	☐	ABNORMAL BLEEDING	☐	☐	KIDNEY DISEASE	☐	☐
UNEXPLAINED WEIGHT LOSS	☐	☐	ANEMIA	☐	☐	OTHER _____	☐	☐
UNEXPLAINED WEIGHT GAIN	☐	☐	BLOOD TRANSFUSION	☐	☐	OTHER _____	☐	☐

PATIENT SIGNATURE	DATE