Michael Pantos, D.M.D., P.A.

Dental Sleep Medicine

DENTAL SLEEP MEDICINE PATIENT INFORMATION

Patient's Name: ______________________________ Age: _____ Birth Date: ___/___/_____Sex: ____
Last First Middle

Home Address: ______________________________ Home Phone: __________________
Street City Zip Code

Patient's Occupation: ______________________________ Work Phone: __________________

Employer: ______________________________ Cell Phone: __________________

Person Responsible for Account: ______________________ Relationship: _________ SSN: ___________

Home Address: ______________________________ Home Phone: __________________
Street City Zip Code

Work Phone: __________________ Cell Phone: __________________ E-mail: ______________________

Name of person to contact if patient cannot be reached: _________________ Relationship: ________ Phone: ____________

Family Dentist**:** ____________________ Address: ______________________ Phone: ____________

Date of most recent dental check-up: __________________ Were the patients teeth cleaned? Yes No

Family Physician: ____________________ Address: ______________________ Phone: ____________

Sleep Physician/Pulmonologist: ____________________ Address: ______________________ Phone: ____________

How did you hear about our office? ______________________ Referred By: ______________________

Is patient covered by Medical Insurance for treatment? Yes No

Primary Policy Holder's Name: ______________________________ Birth Date: ___/___/_______

Employer: ______________________________ SSN: __________________

Insurance Company Name: ______________________ Group # ___________ Policy # _________________

Secondary Policy Holder's Name: ______________________________ Birth Date: ___/___/_______

Employer: ______________________________ SSN: __________________

Insurance Company Name: ______________________ Group # ___________ Policy # _________________

Dental Insurance Carrier: ______________________ Group #:___________ Policy # _________________

FAMILY HISTORY: (Please Circle)

Father's Name: ______________________________ Living? Yes No

Mother's Name: ______________________________ Living? Yes No

Siblings: Yes No Number of Brothers: _____ Number of Sisters: _____

Patient's Marital Status: ______________________ Spouses Name: ______________________________

Patient Living With: Spouse Self Other: _______________

*** **PLEASE ANSWER THE REMAINDER OF THE FORM RELATIVE TO THE PATIENT** ***

MEDICAL HISTORY:

Have you ever had? (Please Circle)

Asthma	Yes	No	Emotional Problems	Yes	No
Anemia	Yes	No	Hearing Disorder	Yes	No
Abnormal Bleeding	Yes	No	Head or Face Injury	Yes	No
Blood Disease	Yes	No	Herpes	Yes	No
Bone Disorders	Yes	No	Hepatitis	Yes	No
Epilepsy	Yes	No	Rheumatic Fever	Yes	No
Endocrine Problems	Yes	No	A.I.D.S. / H.I.V.	Yes	No

Do you have allergies to the following: (Please list or write N/A as needed)

Drugs, Meds or Anesthetics: ___________________ Seasonal grasses: _________________

Latex (gloves, balloons etc.): _________________ Food: ___________________________

Metals (snaps, jewelry etc.): ___________________ Other: __________________________

Height ______ Weight ______ Neck Size _______ Weight gain/loss of 10 lbs. or more in the last year? Yes / No

My normal work (school) hours / days are: ____

Has there been any change in your general health within the past year? ___________________ Explain___________________

Date of most recent physical exam: _______________________

Have you been under the care of a physician during the past two years, other than for a routine examination? Yes /No

Condition: ____

Present drugs and/or medications (Explain Need): ____

____

Birth Defect(s): Yes No Please list: ____

Have you ever had a serious Illness? ______ If Yes, Please Explain___________________________

Have you ever had High Blood Pressure? __________________ Low Blood Pressure? _______________________

Have you ever had Heart Disease/ Angina/Heart Attack/Congestive Heart Failure? _______________ When? ______________

Have you ever had Diabetes? ______________________________ If yes, date of onset ________________

Have you had Bypass Surgery? ___________________________________ When? ____________________

Have you ever had Bronchitis, Emphysema or Asthma? _____________________ When? ____________________

Have you ever had a Stroke? ______________________________________ When? ____________________

Do you smoke? ____________ Number of packs per day? _____________

Have you received medical treatment from an Allergist, or Ears, Nose and Throat Specialist (ENT)?

Yes No If YES When: ______________ Physician: ______________________________________

Have you had any recent surgeries? Please list: ____

Nasal Surgery: ______ Tonsils removed: _________ Adenoids removed: ________

Have you ever had Hiatal Hernia or Acid Reflux? _____________________________

SLEEP HISTORY: *These questions help us understand your sleep habits better*

My complaint(s) is (are):	**I have experienced these symptoms for:**				
☐ Snoring	☐ 1-18 months	☐ 19 months-5 yrs.	☐ 6-10 yrs.	☐ 11-20 yrs.	☐ 20+ yrs.
☐ My Breathing Stops	☐ 1-18 months	☐ 19 months-5 yrs.	☐ 6-10 yrs.	☐ 11-20 yrs.	☐ 20+ yrs.
☐ I'm sleepy	☐ 1-18 months	☐ 19 months-5 yrs.	☐ 6-10 yrs.	☐ 11-20 yrs.	☐ 20+ yrs.
☐ I can't fall asleep or stay asleep	☐ 1-18 months	☐ 19 months-5 yrs.	☐ 6-10 yrs.	☐ 11-20 yrs.	☐ 20+ yrs.
☐ I talk or walk in my sleep	☐ 1-18 months	☐ 19 months-5 yrs.	☐ 6-10 yrs.	☐ 11-20 yrs.	☐ 20+ yrs.

☐ Other,(please explain)t: ____

1. How long does it take you to fall asleep? ____ minutes ____ hours Avg. # hours of sleep you get? ________

2. On average, how many times do you awake during the night? ______ time(s). How long are you awake? __________

3. Work/school day bedtime: _________________ Wakeup time: ______________

4. Day off Bedtime: ___________________________ Wakeup time: ______________

Please answer these questions using the following number scale: (Please Circle)

1 = rarely	**2 = sometimes**	**3 = often**	**4 = frequently**	**5 = always**
(Less than once a month)	***(1-3 times a month)***	***(4-8 times a month)***	***(3-4 times a week)***	***(5-7 times a week)***

5. No matter how much I sleep I get, I wake up feeling tired:	No	1	2	3	4	5
6. If you were able to sleep longer would you feel rested?	No	1	2	3	4	5
7. Do you have a problem with your work performance because you are sleepy or tired?	No	1	2	3	4	5
8. Have you fallen asleep at work?	No	1	2	3	4	5
9. Do you take regular naps?	No	1	2	3	4	5
10. Do you feel sleepy when driving?	No	1	2	3	4	5
11. Does your snoring disturb others?	No	1	2	3	4	5
12. Have you been told you hold your breath or gasp for air when sleeping?	No	1	2	3	4	5
13. Do you wake up short of breath or gasping?	No	1	2	3	4	5
14. Do you have a problem falling asleep and sleeping a full night?	No	1	2	3	4	5
15. My legs seem to move or kick during my sleep at night?	No	1	2	3	4	5
16. Do you clench or grind your teeth during the night?	No	1	2	3	4	5
17. Do you have and significant stress in your life at the present time?	No	1	2	3	4	5
18. Do you sweat excessively during the night?	No	1	2	3	4	5
19. Have you ever had a sleep study before?	Yes	No				
20. Do you have relatives with sleep disorders?	Yes	No				

I have read and understand the above questions, and I certify that I have answered them to the best of my ability. I will not hold the doctor or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signature of individual completing this form (Must be at least 18 yrs. of age): ____

Relationship (if other than patient): _____________________________ Today's Date: _________________________

Do not fill out below this line:

Dr's. Initials: ___________ Date: _____________

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____

____

Signed: ___________________________________ Date Signed: __________
(Patient)

Signed: ___________________________________ Date Signed: __________
(Dental Staff Member)