Medical History Update

Patient Name: _____

Family Physician's Name: _____ City: _____ Phone: (_____) _____

Preferred Pharmacy Information: _____ City: _____ Phone: (_____) _____

Have you had or currently have any of the following conditions?

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease or Attack	❑	❑	High Blood Pressure	❑	❑	Hepatitis	❑	❑	Dry Mouth	❑	❑
Angina Pectoris	❑	❑	Stroke	❑	❑	Liver Disease	❑	❑	Radiation Therapy	❑	❑
Heart Murmur	❑	❑	Emphysema	❑	❑	Fainting or Dizzy Spells	❑	❑	Chemotherapy	❑	❑
Mitral Valve Prolapse	❑	❑	Diabetes	❑	❑	Heart Surgery	❑	❑	Psychiatric Care	❑	❑
Rheumatic Fever	❑	❑	Tuberculosis	❑	❑	Hemophilia	❑	❑	AIDS or HIV Positive	❑	❑
Artificial Heart Valve	❑	❑	Artificial Joints (Hip, Knee)	❑	❑	Asthma	❑	❑	Kidney Trouble	❑	❑
Heart Pacemaker	❑	❑	Arthritis	❑	❑	Thyroid Disease	❑	❑	Drug Addiction	❑	❑
Sleep Apnea	❑	❑	Autism Spectrum Disorder	❑	❑	ADD/ADHD	❑	❑			

Have you ever had surgery? ❑ Yes ❑ No If yes, list all past surgical procedures. _____

_____

Do you have any disease, problem, or condition not listed? ❑ Yes ❑ No If Yes, what? _____

Are you currently under the care of a Physician? ❑ Yes ❑ No If Yes, why? _____

Are you currently taking any medications, drugs, pills, or multivitamins? ❑ Yes ❑ No If Yes, what? Please list below:

_____ _____

_____ _____

_____ _____

_____ _____

Do you have an allergy to local anesthetic? ❑ Yes ❑ No If Yes, what? _____

Do you have an allergy to any other medication(s)? ❑ Yes ❑ No If Yes, what? _____

Do you have an allergy to latex / rubber products/ metals? ❑ Yes ❑ No If Yes, what? _____

Have you ever had a prescription for Bisphosphonate (Fosmax)? ❑ Yes ❑ No

Are you taking a blood thinner (Coumadin, Warfarin)? ❑ Yes ❑ No

Do you use tobacco products (including vaping devices)? ❑ Yes ❑ No

FOR WOMEN ONLY: Are you pregnant? ❑ Yes ❑ No Are you taking Birth Control Pills? ❑ Yes ❑ No

Nearest Relative not living with you: _____ Relation: _____ Phone: (_____) _____

THE ABOVE INFORMATION IS TRUE: To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medication, I will inform the Doctor at the next appointment. If deemed advisable, I grant permission for my Physician to be contracted for details and advice.

X _____ X _____ _____

Patient or Guardian Signature | Provider (Dentist/Hygienist) Signature | Date

(For Office Use Only) Medical History Review: I have reviewed this medical history and have added any changes since my last review.

Initial: _____ Date: _____	Initial: _____ Date: _____	Initial: _____ Date: _____
Dr. Initial: _____	Dr. Initial: _____	Dr. Initial: _____

OVER →

oceanview dental care

Airway Screening Questionnaire

905 Calle Amanecer, Suite 265
San Clemente, CA 92673
(949) 388-0780 OceanViewDentist.com
General & Cosmetic Dentistry

The latest biomedical research is uncovering the link between sleep-related breathing disorders (SRBD) and our overall health. The American Dental Association (ADA) Council on Dental Practice made a Policy Statement emphasizing the important role dental professionals play in screening and either treating or referring for sleep, breathing and airway related disorders. **In compliance with ADA's position statement, we are providing this screening questionnaire to our patients.**

Please check any of the following signs and symptoms that apply to you:

SLEEP/BREATHING:

- ❑ Snoring or Noisy Breathing
- ❑ Pauses, Gasping or Choking
- ❑ Tossing or Kicking
- ❑ Nightly Awakenings
- ❑ Wake Up Unrefreshed
- ❑ Day-Time Drowsiness
- ❑ Nasal Breathing Issues
- ❑ Mouth Breathing
- ❑ Asthma Symptoms
- ❑ Bed Wetting (current or Past)
- ❑ CPAP Use (current or past)

OCCLUSAL/OROFACIAL:

- ❑ Crowded or Rotated Teeth
- ❑ Gaps Between Teeth
- ❑ Uneven Bite or Bite Issues
- ❑ Retruded or Small Jaw
- ❑ "Gummy Smile"
- ❑ Tongue or Lip Tie
- ❑ Swallow or Speech Issues
- ❑ Chapped Lips, Dry Mouth

TMJ/CRANIOFACIAL:

- ❑ Grinding or Clenching
- ❑ Teeth Wear
- ❑ Gum Recession
- ❑ Teeth Sensitivity
- ❑ Headaches or Migraines
- ❑ Jaw or Facial Pain
- ❑ Jaw Clicking or Noise
- ❑ Ringing in the Ear
- ❑ Locked or Limited Jaw
- ❑ Numbness in Hands, Arms
- ❑ Neck or Shoulder Pain
- ❑ Back or Pelvic Pain
- ❑ Dizziness or Vertigo

NEUROMUSCULAR / SYSTEMIC / PSYCHOSOCIAL:

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Arthritis
- ❑ Lupus
- ❑ Ear Infections
- ❑ Acid Reflux (GERD)
- ❑ Fatigue or Tiredness
- ❑ Weight Issues
- ❑ Problems with Memory
- ❑ Problems with Focusing
- ❑ Problems with Learning
- ❑ ADHD or ADD
- ❑ Mood Swings
- ❑ Anxiety or Depression

❑ If none of these symptoms apply to you, please check this box.

Patient Signature: _____ Date:_____

(For Office Use Only) Medical History Review: I have reviewed this medical history and have added any changes since my last review

Initial: _____ Date: _____ Dr. Initial: _____	Initial: _____ Date: _____ Dr. Initial: _____	Initial: _____ Date: _____ Dr. Initial: _____