

**AUTHORIZATION TO RELEASE INFORMATION TO THE BELOW
LISTED REFERRING AND TREATING HEALTH CARE**

PROFESSIONALS:

Doctors Name

Location/Phone

I authorize the release of communications regarding my treatment with _____ including a full report of examination findings, diagnosis, treatment plan, and progress reports to the providers listed above.

Signed _____ Date _____

Daytime Sleepiness Evaluation

Epworth Sleepiness Scale

The Epworth Sleepiness Scale was developed and validated by Dr. Murray Johns of Melbourne Australia. It is a simple, self-administered questionnaire –widely used by sleep professionals in quantifying the level of daytime sleepiness.

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
Sitting and reading	
Watching Television	
Sitting, inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total Score	

Patient Name

Date

Nighttime Sleepiness Evaluation

Screening Tool for Sleep Apnea

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

Please answer the following questions.

1. Snoring

a) Do you snore on most night (> 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 (1)

No (0)

TOTAL

Score

9 points or more

6-8 points

5 points or less

Refer to sleep specialist or order sleep study

Gray area, use clinical judgment

Low probability of sleep apnea

Name _____

Date _____

ALLERGIC REACTIONS

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

- Anesthetics
- Antibiotics
- Aspirin
- Barbituates

- Codeine
- Iodine
- Latex
- Metals

- Penicillin
- Plastic
- Sedatives
- Sulfa

Other: _____

CURRENT MEDICATIONS

Please list all medications you are taking and the reason you take them. Include all over-the-counter medications, vitamins, herbs, etc.

Medication	Dosage	Reason for Taking

See attached list

PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

Treatment and/or Medication	Doctor/Provider Name	Approximate Date of Treatment

I release and give my permission for this office to request information and communicate with the providers listed above.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient is a minor): _____ Date: _____

HEALTH AND MEDICAL HISTORY

- Yes No Are you currently pregnant?
- Yes No Have you sustained injury to: Head Neck Face Teeth Other: _____
- Yes No Do you drink 4 or more cups of coffee per day? Yes No Do you smoke tobacco?
- Yes No Have you had prior orthodontic treatments? Yes No Consume alcohol or take sedatives
- Yes No Trouble breathing through nose

Patient Signature: _____

Date: _____

HEALTH AND MEDICAL HISTORY (CONTINUED)

Do you have, or have you experienced any of the following:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disorder/ Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problem
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve prolaps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Intestinal Disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous System Disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anxiety
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Valve Replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Urinary Tract Disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic Fatigue
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fibromyalgia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cold hands and feet
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bruising Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer of _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty concentrating
		Chemo <input type="checkbox"/> Radiation <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty breathing at night for sleep
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dizziness
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Excessive Thirst
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Birth Defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fluid Retention
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent colds/flu
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent cough
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent ear infections
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gastroesophgeal Reflex (Gerd)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent sore throat
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent awaking at night - number of times _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing impairment
<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of Substance Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Memory Loss
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hay Fever
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Huntington's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Insomnia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle aches
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle fatigue
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle spasms
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle tremors
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Meniere's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Poor circulation
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscular Dystrophy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent weight gain
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neuralgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent weight loss
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoarthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of breath
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ovarian Cyst	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Slow healing sores
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Speech difficulties
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen, stiff or painful joints
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tired muscles
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever			

Additional Information _____

SURGICAL HISTORY *Have you had any of the following:*

<input type="checkbox"/> Yes	<input type="checkbox"/> No	General Anesthesia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Orthognathic Surgery
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Adenoids removed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Oral Surgery
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsils removed	Removal of third molar (wisdom teeth) <input type="checkbox"/> Other <input type="checkbox"/>		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw Joint Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other surgery _____

please list below

Other types of surgery _____

Patient Signature: _____ Date: _____

CURRENT SYMPTOMS

Head Pain

<i>Location</i>			<i>Recent</i>	<i>Chronic</i> <i>(over 6 mo.)</i>	<i>Severity</i>			<i>Duration</i>			<i>Frequency</i>			
<i>L=Left R=Right B=Bilateral</i>					<i>Mild</i>	<i>Mod</i>	<i>Severe</i>	<i>Min.</i>	<i>Hrs.</i>	<i>Days</i>	<i>Occasional</i>	<i>Frequent</i>	<i>Constant</i>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frontal (Forehead)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Generalized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parietal (Top of head)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occipital (Back of head)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Temporal (Temple area)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have pain or discomfort in any of the following areas? If so, please indicate the approximate date the pain began.

Jaw Pain

L R Jaw pain with opening
 L R Jaw pain when chewing
 L R Jaw pain at rest

Jaw Joint Sounds

L R Jaw sounds with opening
 L R Jaw sounds when chewing
 L R Jaw sounds at rest

Jaw Locking

Yes No Jaw locks closed
 Yes No Jaw locks open

Jaw Joint Symptoms

Yes No Teeth clenching Day Night
 Yes No Teeth grinding Day Night

Eye Related Conditions

Yes No Blurred vision
 Yes No Double vision
 Yes No Eye pain

Yes No Pain or pressure behind the eyes
 Yes No Extreme sensitivity to light (photophobia)
 Yes No Wear of glasses or contact lenses

Ear Related Conditions

L R Buzzing in the ears
 L R Ear congestion
 L R Ear pain
 L R Hearing loss
 L R Itchiness or Stiffness in ears

L R Pain behind the ear
 L R Pain in front of the ear
 L R Recurrent ear infections
 L R Ringing in the ear (Tinnitus)

Throat Related Conditions

Yes No Chronic sore throat
 Yes No Difficulty swallowing
 Yes No Swollen glands

Yes No Thyroid enlargement
 Yes No Tightness in throat
 Yes No Constant feeling of a foreign object in throat

Neck Related Conditions

Yes No Limited movement of neck
 Yes No Neck pain

Yes No Numbness in hands or fingers
 Yes No Swelling in the neck

Patient Signature: _____

Date: _____

Shoulder Related Conditions

Yes No Shoulder pain
 Yes No Shoulder stiffness

Yes No Tingling in hands or fingers

Back Related Conditions

Yes No Back pain - lower
 Yes No Back pain - middle
 Yes No Back pain - upper

Yes No Sciatica
 Yes No Scoliosis

Mouth and Nose Related Conditions

Yes No Dry mouth
 Yes No Chronic sinusitis
 Yes No Frequent snoring

Yes No Burning tongue
 Yes No Broken teeth
 Yes No Frequent biting of the cheek

Sleep Conditions

Please select Yes or No answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Positions Side Back Stomach Varies

Average hours of sleep per night? _____

Is it easy to fall asleep? Yes No

Do you wake often during the night? Yes No

Do you feel rested upon AM waking? Yes No

Gasping or Choking during sleep? Yes No

Stopped breathing during sleep? Yes No

Have you ever had a Sleep Study (PSG)? Yes No

Result was _____

HISTORY OF SYMPTOMS

On what date, or approximate date, did this condition or symptoms first occur? _____

Yes No Does any family member have the same or similar problem? If yes, please explain. _____

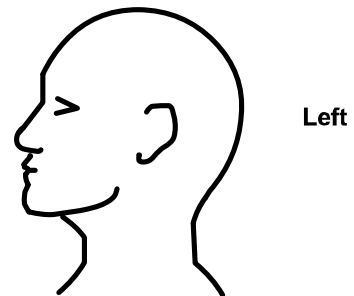
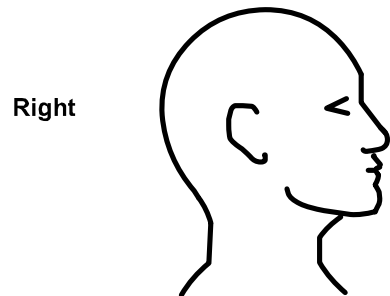
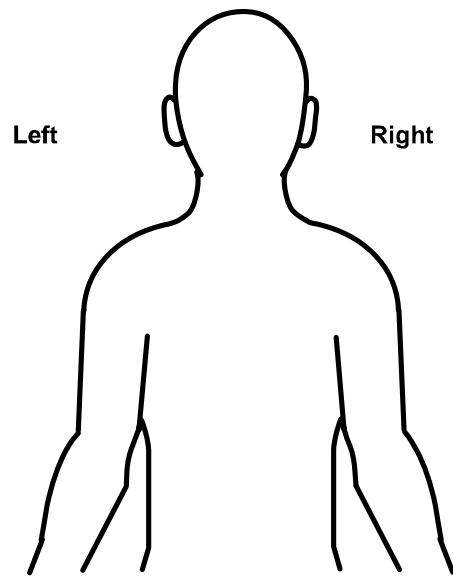
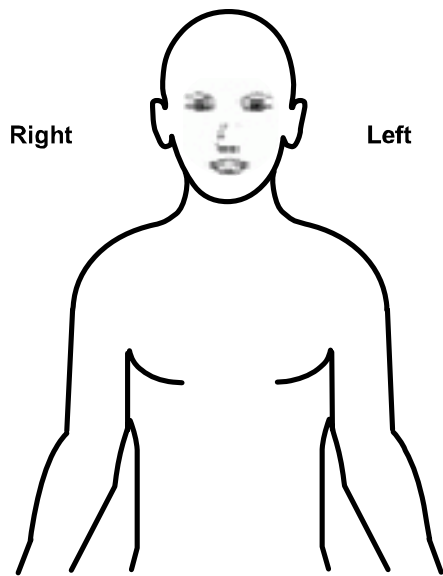
Can you relate your pain or condition to a motor vehicle accident or traumatic injury? _____

If yes, please complete Trauma History Section, enclosed as a separate form.

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient is a minor): _____ Date: _____



Indicate Areas of Pain
Following the Pain Scale:
1 Mild pain
2 Moderate pain
3 Severe pain