HollowBrook Sleep

Patient Health History

_____ _____ _____

PATIENT NAME DOB TODAY'S DATE

DO YOU HAVE ANY OF THE BELOW ALLERGENS?

❑ NONE KNOWN ❑ IODINE ❑ PLASTIC

❑ ANITBIOTICS ❑ LATEX ❑ SEDATIVES

❑ ASPRIN ❑ LOCAL ANESTHETIC ❑ SLEEPING PILLS

❑ BARBITUATES ❑ METALS ❑ SULFA DRUGS

❑ CODEINE ❑ PENICILLIN

OTHER: _____

PLEASE LIST ANY CURRENT MEDICATIONS.

MEDICINE	DOSAGE/FREQUENCY	PURPOSE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HISTORY OF SIGNIFICANT MEDICAL CONDITIONS.

	NEVER	CURRENTLY	PAST	LAST KNOWN DATE/NOTES
ACID REFLUX	❑	❑	❑	_____
ANEMIA	❑	❑	❑	_____
ATHEROSCLEROSIS	❑	❑	❑	_____
ARTHRISTIS	❑	❑	❑	_____

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ASTHMA	❑	❑	❑	_____
AUTOIMMUNE DISORDER	❑	❑	❑	_____
BLEED EASILY	❑	❑	❑	_____
HIGH BLOOD PRESSURE	❑	❑	❑	_____
LOW BLOOD PRESSURE	❑	❑	❑	_____
BRUISE EASILY	❑	❑	❑	_____
CANCER	❑	❑	❑	_____
CHEMOTHERAPY	❑	❑	❑	_____
CHRONIC FATIGUE	❑	❑	❑	_____
CHRONIC PAIN	❑	❑	❑	_____
COPD	❑	❑	❑	_____
CORONARY HEART DISEASE	❑	❑	❑	_____
CURRENTLY PREGNANT	❑	❑	❑	_____
DEPRESSION	❑	❑	❑	_____
DIABETES	❑	❑	❑	_____
DIFFICULTY SLEEPING	❑	❑	❑	_____
DIZZINESS	❑	❑	❑	_____
EMPHYSEMA	❑	❑	❑	_____
EPILEPSY	❑	❑	❑	_____
EXCESSIVE DAYTIME SLEEPINESS	❑	❑	❑	_____
FIBROMYALGIA	❑	❑	❑	_____
GLAUCOMA	❑	❑	❑	_____
GOUT	❑	❑	❑	_____
HEART ATTACK	❑	❑	❑	_____
HEART MURMUR	❑	❑	❑	_____
HEART PACEMAKER	❑	❑	❑	_____
HEART VALVE REPLACEMENT	❑	❑	❑	_____
HEMOPHILIA	❑	❑	❑	_____
HEPATITIS	❑	❑	❑	_____
HIV/AIDS	❑	❑	❑	_____
HYPERTENSION	❑	❑	❑	_____
HYPOGLYCEMIA	❑	❑	❑	_____
IMMUNE SYSTEM DISORDER	❑	❑	❑	_____
INSOMINA	❑	❑	❑	_____
ISCHEMIC HEART DISEASE	❑	❑	❑	_____
KIDNEY PROBLEMS	❑	❑	❑	_____
LIVER DISEASE	❑	❑	❑	_____
MENIERE'S DISEASE	❑	❑	❑	_____
MITRAL VALVE PROLAPSE	❑	❑	❑	_____
MOOD DISORDER	❑	❑	❑	_____
MULTIPLE SCLEROSIS	❑	❑	❑	_____
MUSCULAR DYSTROPHY	❑	❑	❑	_____
NASAL ALLERGIES	❑	❑	❑	_____

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NEURALGIA	❑	❑	❑	_____
OSTEOARTHRITIS	❑	❑	❑	_____
OSTEOPOROSIS	❑	❑	❑	_____
PARKINSON'S DISEASE	❑	❑	❑	_____
PRIOR ORTHODOTIC TREAMENTS	❑	❑	❑	_____
RADIATION TREATMENT	❑	❑	❑	_____
RECREATIONAL DRUG USE	❑	❑	❑	_____
RHEUMATIC FEVER	❑	❑	❑	_____
RHEUMATOID ARTHRITIS	❑	❑	❑	_____
SINUS PROBLEMS	❑	❑	❑	_____
SLEEP APNEA	❑	❑	❑	_____
STROKE	❑	❑	❑	_____
TENDENCY FOR EAR INFECTIONS	❑	❑	❑	_____
THYROID DISORDER	❑	❑	❑	_____
TUBERCULOSIS	❑	❑	❑	_____
TUMORS	❑	❑	❑	_____
URINARY DISORDERS	❑	❑	❑	_____

HISTORY OF SURGICAL PROCEDURES

❑ APPENDECTOMY	❑ HEART	❑ THYROID
❑ BACK	❑ HERNIA REPAIR	❑ TONSILLECTOMY
❑ EAR	❑ LUNG	❑ UVULECTOMY
❑ GALLBLADDER	❑ NASAL	❑ PERIODONTAL

OTHER: _____

FAMILY MEDICAL HISTORY (PARENTS, SIBLINGS, GRANDPARENTS)

❑ CANCER	❑ STROKE	❑ FATHER SNORES
❑ HEART DISEASE	❑ SLEEP DISORDER	❑ MOTHER SNORES
❑ DIABETES	❑ OBESITY	❑ FATHER SLEEP APNEA
❑ HIGH BLOOD PRESSURE	❑ THYROID DISORDER	❑ MOTHER SLEEP APNEA

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Patient Health History

SOCIAL HISTORY

_____ _____

PATIENTS OCCUPATION CURRENT EMPLOYER

TOBACCO USE

❑ NEVER SMOKED

❑ CURRENT SMOKER PACKS SMOKED PER DAY? _____ # OF YEARS SMOKING _____

❑ QUIT SMOKING DATE YOU QUIT? _____ # OF YEARS SMOKED _____

ALCOHOL USE

DO YOU DRINK ALCOHOL? ❑ YES ❑ NO NUMBER OF DRINKS PER WEEK? _____

CAFFEINE USE

❑ NONE ❑ COFFEE ❑TEA ❑SODA NUMBER OF CUPS PER DAY? _____

EXERCISE

NUMBER OF DAYS PER WEEK? _____

I CERTIFY THAT THE MEDICAL HISTORY IS COMPLETE AND ACCURATE.

_____ _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE

Because of HIPPA Federal Regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required, including a full report of examination findings, diagnosis and treatment program(s) to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits payable for related services.

_____ _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE