SUPPLEMENTARY HEALTH QUESTIONNAIRE

Patient Name: _____Today's Date: _____

Have there been any changes in your medical history since your last visit? Yes _____ No _____

Has anyone ever commented or told you that you snore? Yes _____ No _____
If yes, how often: rarely _____ sometimes _____ often _____ most nights _____

Has anyone ever heard you stop breathing or choking at night? Yes _____ No _____

On an energy level, 10 being the most active and energetic. How would you rate yourself on most days?
(Circle one) 1…..2…..3…..4…..5…..6…..7…..8…..9…..10

Have you been diagnosed with a sleep disorder? Yes _____ No _____
*If yes, h*ave you been prescribed CPAP therapy? Yes _____ No _____
If yes, do you wear your CPAP and how often?
every night_____ most nights_____ couple nights per week _____ never_____

Do you experience headaches or migraines regularly? Yes _____ No _____
If yes, how often: rarely _____ sometimes _____ often _____
What medications to you take? _____

Do you knowingly grind your teeth at night or have been told by a dentist that you may be grinding?
If yes, do you wear a night guard? Yes _____ No _____

Have you ever had a problem with your TMJ /TMD jaw joint? Yes _____ No _____

Are you happy with the appearance of your teeth? Yes _____ No _____
If no, are you dissatisfied with: *(circle all that apply)*

Color _____ Looks of previous fillings / crowns _____
Shape _____ Condition / Level of gums _____
Spacing _____ Other _____
Crowding ____

Are you interested in knowing more about our home whitening system? Yes _____ No _____

Have you noticed a bad taste/odor in your mouth on a frequent basis? Yes _____ No _____

Are you regularly involved in sports? Yes _____ No _____
List sports? _____

Would you like to know more about our custom athletic sports guards for you or a family member?
Yes _____ No _____

Are you interested in knowing about permanent tooth replacement? Yes _____ No _____
or implant tooth replacement? Yes _____ No _____