Dental Group at Reston Station

Patient Health Information/
Epworth Test

HEALTH INFORMATION

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female Date of Birth: _____ Date of Last Dental Visit/Cleaning: _____

Reason for today's visit: _____

Have you ever had any of the following? Please check box below Yes or No.

Y	N			
☐	☐	Arthritis	Type: _____	
☐	☐	Artificial joint	Type: _____	Date: _____
☐	☐	Asthma		
☐	☐	Abnormal bleeding after a dental procedure		
☐	☐	Autoimmune disorders	Type: _____	
☐	☐	Bleeding/blood disorders	Type: _____	
☐	☐	Blood transfusions		
☐	☐	Cancer(s)	Type: _____	Date: _____
☐	☐	Chemotherapy or Radiation treatment		Date: _____
☐	☐	Cortisone or Steroid treatment		Date: _____
☐	☐	Dementia	Type: _____	
☐	☐	Diabetes	Type: _____	
☐	☐	Drug - alcohol addiction/dependency/abuse		
☐	☐	Emphysema		
☐	☐	Epilepsy or Seizures		
☐	☐	GERD/Reflux		
☐	☐	Heart condition ☐ Heart murmur ☐ Mitral valve prolapse ☐ Artificial heart valve/endocarditis/Angina/CHF		
☐	☐	Heart surgery	Type: _____	Date: _____
☐	☐	High blood pressure		
☐	☐	High cholesterol		
☐	☐	HIV positive or Acquired Immune Deficiency Syndrome, Herpes, HPV or other STD: _____		
☐	☐	Kidney problem	Type: _____	Dialysis: _____
☐	☐	Leukemia	Type: _____	
☐	☐	Liver problem	Hepatitis Type: ☐ A ☐ B ☐ C ☐ D	Other: _____
☐	☐	Organ transplant(s)	Type: _____	Date: _____
☐	☐	Currently pregnant	How many weeks: _____	Due Date: _____
☐	☐	Nursing		
☐	☐	Osteoporosis		
☐	☐	Neurological disorder	MS: _____ Parkinson's: _____	Headaches: _____ Other: _____
☐	☐	Psychiatric treatment	Depression: ____ Other: _____	
☐	☐	Rheumatic fever or Scarlet fever		
☐	☐	Stroke		
☐	☐	Thyroid problem	Type: _____	
☐	☐	Tobacco use	Type: _____	How much: _____ How long: _____
☐	☐	Tuberculosis	Date: _____	
☐	☐	Other: _____		

Drug allergies or reactions? Please check box below Yes or No.

Y / N		Y / N		Y / N	
☐	☐ Amoxicillin/Penicillin	☐	☐ Clindamycin	☐	☐ Metals
☐	☐ Aspirin or aspirin compounds	☐	☐ Latex allergy	☐	☐ Tetracycline
☐	☐ Codeine or Demerol	☐	☐ Local anesthesia (epinephrine sensitive)	☐	☐ None

Other: _____

Please list current medications, vitamins, herbal supplements and dosage:

_____

_____

_____

Are you currently under care of a physician? _____ Physician's name/number: _____

Have you been hospitalized in the last 4-5 years? _____

Reason: _____

Do you have any other health conditions that need further clarifications? _____

_____

_____

General Health Questionnaire. Please check box below Yes or No.

Y / N

☐ ☐ Have you been diagnosed with Obstructive Sleep Apnea?
If Yes, are you using: ☐ CPAP Machine ☐ Oral Device

☐ ☐ Do your gums bleed while brushing/flossing? _____

☐ ☐ Have you or a family member ever lost teeth to periodontal disease? _____

☐ ☐ Are you under orthodontic treatment or have had orthodontic treatment in the past? _____

☐ ☐ Do you participate in any sports? _____

☐ ☐ Do you feel any sensitivity to hot, cold, or sweets? _____

☐ ☐ Do you feel any discomfort with chewing? _____

☐ ☐ Are you happy with your smile? _____

☐ ☐ Would you like your teeth whiter? _____

☐ ☐ Do you have or ever had any jaw joint trouble/treatment? If so, by whom: _____

☐ ☐ Do you have DRY mouth? _____

EPWORTH SLEEP TEST

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the following scale to choose the most appropriate number for each situation.

0 = Would never doze 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing.

Situation: Chance of Dozing

_____ 1. Sitting and reading
_____ 2. Watching television
_____ 3. Sitting, inactive in a public place
_____ 4. As a passenger in a car for an hour without a break
_____ 5. Lying down in afternoon when circumstances permit
_____ 6. Sitting and talking to someone
_____ 7. Sitting quietly after lunch without alcohol
_____ 8. In a car, while stopped for a few minutes in traffic

_____ **Total Estimated Score**

The Epworth Sleep Test is a tool, not a diagnosis. However, if your EST score is:

1-6 Obstructive Sleep Apnea is less likely
7-8 Your Score is Average
9 or Higher Obstructive Sleep Apnea is more likely and you should contact us for a consultation

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To the best of my knowledge, all of the information I have provided is accurate/true. If there is a change in my health at future appointments, I will inform the doctor(s) of change.

_____ Date: _____ Doctor's initials: _____

Signature of patient, parent or legal guardian if under 18 years old

OFFICE PRIVACY POLICY

Our office always attempts to protect the privacy of our patients. We comply with all federal (HIPAA), state and local regulations regarding this issue. A copy of our privacy policy is available upon request and is posted in the waiting room for public viewing. Information regarding your care is only shared as a professional necessity; no information is shared for any other reason.

I ACKNOWLEDGE THAT I HAVE SEEN AND/OR RECEIVED A COPY OF THE OFFICE'S PRIVACY POLICY.

Patient/Guardian Signature: _____