

# Health History Form

Email: \_\_\_\_\_ Today's Date: \_\_\_\_\_

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: <i>Last First Middle</i>			Home Phone: <i>Include area code</i> ( )	Business/Cell Phone: <i>Include area code</i> ( )	
Address: <i>Mailing address</i>			City:	State:	Zip:
Occupation:	Height:	Weight:	Date of Birth:	Sex: M F	
SS# or Patient ID:	Emergency Contact:	Relationship:	Home Phone: <i>Include area code</i> ( )	Cell Phone: <i>Include area code</i> ( )	
If you are completing this form for another person, what is your relationship to that person?					
<i>Your Name</i>			<i>Relationship</i>		
<b>Do you have any of the following diseases or problems:</b>			<i>(Check DK if you Don't Know the answer to the the question)</i>		<b>Yes No DK</b>
Active Tuberculosis.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.</b>					

## Dental Information *For the following questions, please mark (X) your responses to the following questions.*

<b>Yes No DK</b>	<b>Yes No DK</b>
Do your gums bleed when you brush or floss?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:
If yes, how often? <i>Circle one:</i> DAILY / WEEKLY / OCCASIONALLY	What was done at that time?
Are you currently experiencing dental pain or discomfort?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays:
What is the reason for your dental visit today?	
How do you feel about your smile?	

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

<b>Yes No DK</b>	<b>Yes No DK</b>
Are you now under the care of a physician?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i> ( )	If yes, what was the illness or problem?
Address/City/State/Zip:	Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you in good health?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:
Has there been any change in your general health within the past year?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____
If yes, what condition is being treated?	_____
Date of last physical exam:	_____

# Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p><i>(Check DK if you Don't Know the answer to the question)</i></p> <p>Do you wear contact lenses? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date Treatment began: _____</p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Do you use controlled substances (drugs)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p><b>WOMEN ONLY</b> Are you:</p> <p>Pregnant? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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<p><b>Allergies.</b> Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.</p> <p>Local anesthetics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Codeine or other narcotics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Metals ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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**Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.**

<p style="text-align: right;"><b>Yes No DK</b></p> <p>Artificial (prosthetic) heart valve ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Previous infective endocarditis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged valves in transplanted heart ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congenital heart disease (CHD)</p> <p style="padding-left: 20px;">Unrepaired, cyanotic CHD ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired (completely) in last 6 months ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired CHD with residual defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Autoimmune disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatoid arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Systemic lupus erythematosus ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Bronchitis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus trouble ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer/Chemotherapy/ Radiation Treatment ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest pain upon exertion ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic pain ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes Type I or II ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eating disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Malnutrition ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Gastrointestinal disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>G.E. Reflux/persistent heartburn ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcers ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid problems ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Glaucoma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis, jaundice or liver disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting spells or seizures ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Neurological disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, specify: _____</p> <p>Sleep disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you snore? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mental health disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Specify: _____</p> <p>Recurrent Infections ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Type of infection: _____</p> <p>Kidney problems ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Night sweats ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Osteoporosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent swollen glands in neck ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe headaches/ migraines ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe or rapid weight loss ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sexually transmitted disease .. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive urination ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

<p style="text-align: right;"><b>Yes No DK</b></p> <p>Cardiovascular disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arteriosclerosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congestive heart failure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged heart valves ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart attack ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart murmur ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Low blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>High blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other congenital heart defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Mitral valve prolapse ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pacemaker ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic fever ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic heart disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Abnormal bleeding ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood transfusion ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, date: _____</p> <p>Hemophilia ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS or HIV infection ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: *Include area code*  
(    )

Do you have any disease, condition, or problem not listed above that you think I should know about? .....

Please explain: \_\_\_\_\_

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Insurance Information:

**Primary Insurance Carrier:** \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Address to submit the claim:

\_\_\_\_\_

Street City State Zip Code \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Child: \_\_\_\_\_

Employer Name: \_\_\_\_\_

**Secondary Insurance Carrier:** \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Address to submit the claim:

\_\_\_\_\_

Street City State Zip Code \_\_\_\_\_

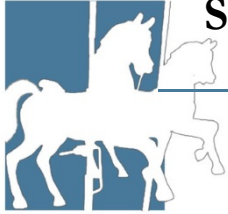
Policy Holder's Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Child: \_\_\_\_\_

Employer Name: \_\_\_\_\_

**I DO NOT YOU HAVE ANY OTHER INSURANCE COVERAGE FROM ANY  
OTHER SOURCE OTHER THAT THE ABOVE MENTIONED. Initial \_\_\_\_\_**



**Steven Shandley, D.D.S.**  
**M. Elizabeth Kane, D.D.S.**

Family Dental Care

### Acknowledgement of Receipt of Notice of Privacy Practices

\* You May Refuse to Sign This Acknowledgment\*

I have received/ been offered a copy of this office's Notice of Privacy Practices.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I give permission to leave health information and/ or appointment information on my answering system at:  
(Please check all that apply)

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ (Initial)

I give permission to discuss health care information with:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Contact number \_\_\_\_\_ (Initial)

May we have your permission to show our appreciation and send a thank you to the person who referred you to our practice? (Please circle one) Yes or No

\_\_\_\_\_ (Initial)

#### Right to Revoke:

I have the right at any time to revoke this Acknowledgement for any reason.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### E-mail Statement and Acknowledgment:

It is our office's goal to keep your information confidential and secure. Being that most E-mail systems are unencrypted, there are inherent risks with E-mail (e.g. interception, alteration). If you understand the risks associated with E-mail and would still like to be communicated with in that way, please acknowledge below.

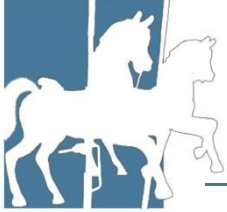
\_\_\_\_\_ (Initial)

#### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)



**Steven Shandley, D.D.S.**  
**M. Elizabeth Kane, D.D.S.**

Family Dental Care

### HIPAA Consent To Leave A Message

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(print)

I wish to be called at: (fill all that apply)

Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Other: \_\_\_\_\_

#### **Regarding my care and follow-up.**

- I do
- I do not

Give permission to leave relevant medical information on my answering machine or voice mail. These might include: treatment plans, pre-medication reminders, and general Protected Health Information.

- I do
- I do not

Want relevant medical information to be shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave Protected Health Information are:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	Dose	How Often Do You Take the Medication	Reason for taking medication	Prescriber

### Known Allergies:

List any reaction you have experienced from medicines that have had bad side effects. Also include any allergy to dye, food, etc.


**Signature:**

**Date:**

# Watermark Medical ARES Questionnaire

**PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX**

First Name		Middle Initial		Last Name		Tally ARES Risk Points
Weight	Pounds	Age	Years	Gender Male <input type="radio"/> Female <input type="radio"/>		
Height	Feet	Inches	Neck Size		Inches	Neck Size +2 Male ≥16.5 +2 Female ≥15.0
Date of Birth	Month	Day	Year	ID Number	Optional	Score <input style="width: 40px; height: 20px;" type="text"/>

**COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS**

<b>Have you been diagnosed or treated for any of the following conditions?</b>						Co-morbidities +1 for each Yes response
High blood pressure	Yes <input type="radio"/>	No <input type="radio"/>	Stroke	Yes <input type="radio"/>	No <input type="radio"/>	
Heart disease	Yes <input type="radio"/>	No <input type="radio"/>	Depression	Yes <input type="radio"/>	No <input type="radio"/>	Score <input style="width: 40px; height: 20px;" type="text"/>
Diabetes	Yes <input type="radio"/>	No <input type="radio"/>	Sleep apnea	Yes <input type="radio"/>	No <input type="radio"/>	
Lung disease	Yes <input type="radio"/>	No <input type="radio"/>	Nasal oxygen use	Yes <input type="radio"/>	No <input type="radio"/>	Do not assign any points for these eight responses
Insomnia	Yes <input type="radio"/>	No <input type="radio"/>	Restless leg syndrome	Yes <input type="radio"/>	No <input type="radio"/>	
Narcolepsy	Yes <input type="radio"/>	No <input type="radio"/>	Morning Headaches	Yes <input type="radio"/>	No <input type="radio"/>	
Sleeping Medication	Yes <input type="radio"/>	No <input type="radio"/>	Pain Medication e.g., vicodin, oxycontin	Yes <input type="radio"/>	No <input type="radio"/>	

<p><b>Epworth Sleepiness Scale:</b> How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)</p> <p>0 = would never doze                      1 = slight chance of dozing 2 = moderate chance of dozing          3 = high chance of dozing</p>						Epworth Score <b>TOTAL</b> the values from all 8 questions, if 11 or less Score = 0 if 12 or more Score = 2			
Sitting and reading	0	1	2	3	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting, inactive, in a public place (theater, meeting, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As a passenger in a car for an hour without a break	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down to rest in the afternoon when circumstances permit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and talking to someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting quietly after lunch without alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In a car, while stopped for a few minutes in traffic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
							Score <input style="width: 40px; height: 20px;" type="text"/>		

<b>Frequency</b>	0 - 1 times/week	1 - 2 times/week	3 - 4 times/week	5 - 7 times/week	
<b>On average in the past month, how often have you snored or been told that you snored?</b>					
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost always <input type="radio"/>	+4
<b>Do you wake up choking or gasping?</b>					
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost always <input type="radio"/>	+4
<b>Have you been told that you stop breathing in your sleep or wake up choking or gasping?</b>					
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost always <input type="radio"/>	+4
<b>Do you have problems keeping your legs still at night or need to move them to feel comfortable?</b>					
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost always <input type="radio"/>	

Signature	Area Code	Phone Number	<b>Total all 6 boxes from above</b> If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	<b>Point Total</b> <input style="width: 40px; height: 20px;" type="text"/>
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