Katharine Christian DMD

2101 4th Avenue • Suite 2330 • Seattle, WA 98121 Ph (206) 770-0260 Fax (206) 770-0182
www.sleep911.com

PERSONAL & HEALTH HISTORY

DATE_____ NAME_____ BIRTH DATE_____ SEX: **M** **F**

Occupation _____ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant other ☐

Height:_____ft._____Weight:_____# Weight gain/loss: In past year #:_____In past 5 yrs #:_____

Have you had an overnight sleep study? **Y** **N** Sleep Center_____Study date _____

Have you been diagnosed with Obstructive Sleep Apnea (OSA)? **Y** **N** _____

OSA Diagnosis : Mild ___ Mod ___ Severe___ Diagnosing Sleep Physician_____

Most noticeable symptom related to your **OSA**_____

Please "x" any of the following that you now have or have had in the past:

☐ Heart condition	☐ Sinus problems	☐ Head/neck injury	☐ Snore	☐ Smoke Quit? ☐ When?_____
☐ High blood pressure	☐ Chronic headaches	☐ Whip lash injury	☐ Gasp	☐ Allergies/Hay fever
☐ Have a pacemaker	☐ Tonsillectomy	☐ Jaw-joint pain	☐ Asthma	☐ Orthodontics (braces)
☐ Respiratory condition	☐ Nose Surgery	☐ Grind your teeth	☐ Weight gain	☐ Use alcohol
☐ Thyroid condition	☐ Loss of memory	☐ Clench your teeth	☐ Hepatitis: A B C	☐ Arthritis RA OA
☐ Diabetes	☐ Hard to concentrate	☐ Depression	☐ Acid reflux	☐ Fibromyalgia
☐ Stroke	☐ Tuberculosis	☐ Sexually transmitted disease		☐ AIDS/HIV
☐ TIA	☐ Parkinson's disease	☐ Epilepsy/Seizure disorder		☐ Cancer - Current? ☐
☐ Alzheimer's/dementia				

Please list any other health conditions that we should be aware of_____

_____

Preferred sleeping position in order of preference 0-4: **Back____ Right. Side____ Left. Side____ Stomach____**

Other Surgeries, etc:_____

_____

List medications you are currently taking, dosages & reason for use (use reverse side if more space required):

_____

_____

General Dentist_____ Mailing Address_____

Ph:_____ Fax:_____email:_____

Last Treatment date_____ Are you planning any dental treatment or surgery? **Y** **N** If yes, describe:

_____

Do you wear any removable dental appliances (night guard, orthodontic retainer, dentures, partials)? **Y** **N**

Please describe_____

_____ _____ _____

SIGNATURE **PRINTED NAME** **DATE**