SchopeDental

Please circle the appropriate response

Any changes in your health history in the last 6 months..........................yes no

Any changes in your medications in the last 6 months.............................yes no

In the last 6 months, any change in your mailing address........................yes no

Any change in your dental insurance since last visit................................yes no

Cell number: ___________________ Authorized to receive text? ....yes no

Primary e-mail address: ___________________________________

Health History Supplement

Do you, or has anyone told you, that you snore?...............................yes no

Do you experience daytime sleepiness and tiredness?......................yes no

Do you usually sleep through the night?..yes no

Do you have high blood pressure?...yes no

Have you woken up suddenly with shortness of breath,
gasping, or with your heart racing?..yes no

Do you have or have you ever had Acid Reflux or Heartburn issues? yes no

Have you ever been diagnosed with sleep apnea?............................yes no

Family history of sleep apnea? ....yes no

Do you wear an oral sleep appliance or a CPAP for sleep apnea?.......yes no