

Dr. Tran Miller, DMD

199 SW Shelvin Hixon Drive, Suite A ● Bend, OR 97702

P: (541)330-5952 F: (541)330-5935

Name: _____ DOB: _____

Height: _____ Weight: _____ Email: _____

Medical and Sleep History

Check all that apply

Sleep Symptoms:

- | | |
|--|--|
| <input type="checkbox"/> Frequent bathroom visits nightly | <input type="checkbox"/> Teeth grinding/clenching |
| <input type="checkbox"/> Waking up paralyzed | <input type="checkbox"/> Gasping, choking or snorting during sleep |
| <input type="checkbox"/> Audible or visual hallucinations during sleep | <input type="checkbox"/> Restless legs |
| <input type="checkbox"/> Family history of sleep apnea | <input type="checkbox"/> Limbs jerking/twitching at night |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Morning headaches |
| <input type="checkbox"/> Tension Headaches | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Restless sleep |
| <input type="checkbox"/> Snoring | |

Medical History:

- | | |
|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Oxygen use |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Other lung disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Gastric acid reflux | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Atrial fibrillation |
| <input type="checkbox"/> Polycystic ovarian syndrome | |

Alcohol consumption:

Daily Weekly 3-5 times weekly Weekends Special occasions

Previous oral/nasal surgery? No Yes, please specify: _____
