MC Dental Care, PLLC

Home of the WOW!

"Creating Healthy Smiles For Life"

Name: _____ Date: _____

RATE YOUR SMILE

HOW HAPPY ARE YOU WITH IT?

1 2 3 4 5 6 7 8 9 10

(1 Lowest - 10 Highest)

WHAT ARE 3 THINGS YOU WOULD CHANGE?

#1_____

#2_____

#3_____

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Medical Record Questionnaire

Have you ever been given a CPAP device? ☐ Y ☐ N

If you have been given a CPAP device, do you use it every night? ☐ Y ☐ N

Are you comfortable with your CPAP and satisfied with its use? ☐ Y ☐ N

If you answered YES to all three of these questions, you are done, thank you! If you answered NO to any of these questions, please continue.

How likely, are you to doze off while doing the following activities? Please use the following scale: 0= Never, 1= Slight, 2= Moderate, 3= High. Circle one of the following numbers.

Being a passenger in a motor vehicle for an hour or more ……	0 1 2 3
Sitting and talking to someone……	0 1 2 3
Sitting and reading……	0 1 2 3
Watching TV……	0 1 2 3
Sitting inactive in a public place……	0 1 2 3
Lying down to rest in the afternoon……	0 1 2 3
Sitting quietly after lunch without alcohol……	0 1 2 3
In a car, while stopped for few minutes in traffic……	0 1 2 3

Have you ever been told you snore?	☐ Y ☐ N
Do you wake up choking or gasping?	☐ Y ☐ N
Have you have high blood pressure?	☐ Y ☐ N
Do you have diabetes?	☐ Y ☐ N
Have you ever experienced an irregular heart rhythm?	☐ Y ☐ N

FOR OFFICE USE ONLY:

PART 3

Neck Size_____ (Female >15, Male > 16.5)

Height_____ Weight_____

BMI_____ (>30) Mallampati_____ (Class III & Greater) Scalloped Tongue_____

PART 4

Does snoring cause any problems at home?	☐ Y ☐ N
Would you like to fix that? (If yes to above question)	☐ Y ☐ N

Print Name _____ Birthday_____

Signature _____ Date _____