APOLLONIA DENTAL

Health History Update

Thank you for choosing Apollonia Dental for your biological dental needs. In order to best serve you, please answer all questions to the best of your knowledge, and do not skip anything, as this could interfere with the effective handling of your insurance claims, statements, communication(s) with referring doctors and/or the proper care you receive from Dr. Dunnington and her staff.

Today's Date _____/_____/_____

_____(_____)
Last Name **First Name** **Preferred Name**

(_____) _____-_____ (_____) _____-_____ _____
Phone (Primary) **Phone (Secondary)** **Email**

_____
Mailing Address **City** **State** **Zip**

_____ (_____) _____-_____ _____
Emergency Contact Name **Phone (Primary)** **Relationship to Patient**

_____ (_____) _____-_____ _____
Pharmacy Name **Pharmacy Phone** **Address/Cross Streets**

_____ (_____) _____-_____ _____
Dental Insurance Co Name **Phone (for Dental Providers)** **Member/Subscriber ID#**

_____ _____/_____/_____ _____
Subscriber Name (If other than yourself) **Subscriber dob** **Subscriber's Employer**

Are you taking any medications for Osteopenia/Osteoporosis or Bone Disease?

☐ Yes ☐ No

Have you taken or are you taking Fosamax, Boniva or any other Bisphosphonate Drug in the past?

☐ Yes ☐ No

Do you have your gallbladder?

☐ Yes ☐ No

Please list all *medications* or *supplements* currently being taken including but not limited to the following:

- Antibiotics
- Anticoagulants
- Barbiturates
- Anti-Depressants
- Blood Thinners
- Osteoporosis Med.
- Cortisone/Steroids
- Sleeping Medications
- Diet Pills
- Heart Medication
- Insulin
- Stomach Med.
- Muscle Relaxants
- Nerve medications
- Pain Medications
- Cholesterol Med.

☐ **Check this box if you are not taking any medications or supplements.**

Name	Dosage/Frequency	Purpose	Additional info

*****Additional medications or supplements may be written in the last page of this form.**

Please circle or add any medications or substances that have caused an allergic reaction:

☐ **Check this box if you do not have any *known* allergic reactions.**

Known Allergies to:	Specific Reaction:	Additional Information:
Antibiotics		
Aspirin		
Barbiturates		
Codeine		
Iodine		
Latex		
Local Anesthetic		
Metals		
Penicillin		
Plastics		
Sedatives		
Sulfa Drugs		

*****Additional allergies and specific reasons may be written in the last page of this form.**

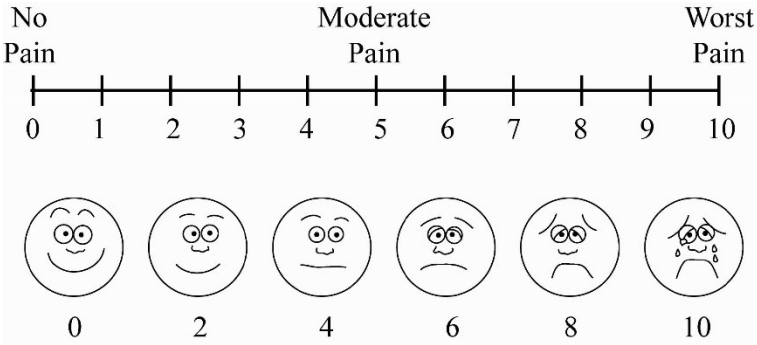
Please list your other doctors and healthcare professionals below:

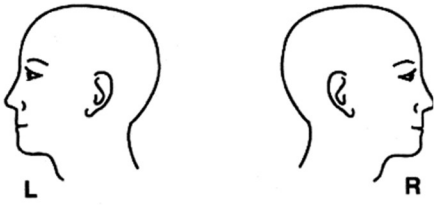
Name	Specialty	Type of Treatment	Phone Number	Last Visit

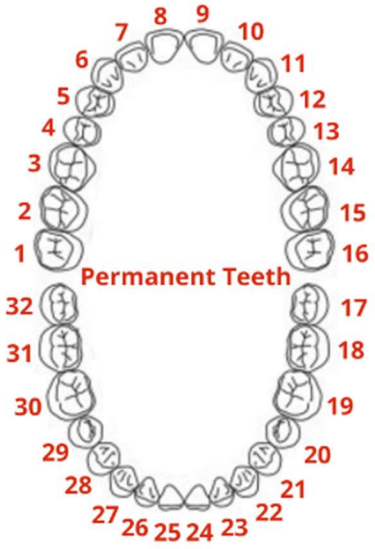
*****Additional doctors and healthcare professionals may be written in the last page of this form.**

1) Please mark (X) any areas of pain, discomfort, or concern that you are feeling.
2) Write *a number* to indicate the severity it feels on that spot or area as follows:

3) ☐ *Check this box if you do not have any pain, discomfort, or concerns.*







Please circle all that apply to you.

Teeth	Mouth	
Broken teeth	*Bad bite*	*Overbite ("bucked teeth")*
Chipped/worn teeth	Burning tongue	*Persistent/Wandering dental sensitivity*
Crowded teeth	*Deep overbite (weak chin)*	*Prior orthodontics*
Discolored	Difficulty Swallowing	*Scratchy, itchy throat*
Frequent cavities	*Dry mouth and/or lips*	Sore throat without infection
History of teeth extraction for braces/orthodontics	Feeling of object in throat	Sour/Bad taste
I DO NOT like my smile	Frequent coughing or clearing	*Speech difficulty*
I want to change my smile	*Frequent sore throat*	*Sunken lips and reverse smile curve (sad look)*
Injury to teeth	*History of lots of dental work*	*Throat infections*
Lingual bar(s) after braces	*Inability to find bite*	*Tongue has teeth prints on side (scalloping)*
Missing teeth	*Injury to mouth*	*Tongue-tie or history of tongue-tie release*
Spacing	*Mouth breathing*	*Tonsils removed*
Teeth grinding	Mouth discomfort	*Underbite ("bulldog jaw")*
Wisdom teeth extracted	*On-going myofunctional therapy*	

Gums	Habits	Digestion
Bad Breath	Cheek/Lip biting	*Acid reflux*
Bony outgrowth on palate or inside lower jaw (Tori and/or Exostosis)	Chew on ice/hard objects	*Bloating/Bloating after meals*
Gums bleeding	E-cigarettes or vaping	*Cannot tell if feeling full or not after eating or drinking*
Gum recession	Finger Sucking	*Food intolerance*
Gums Swollen	History of alcohol abuse	Intestinal disorder
Painful	History of drug abuse	*Poor digestion*
Periodontal Disease	Nail-biting	*Poor stool elimination*
Ulcers	Use tobacco products	

Jaw	Head & Face	Neck, Shoulders & Back
Abnormal/Limited mouth opening	Back of the head aches	*Double chin*
Clicking or Popping sound from jaw joint	Dizziness	*Female: neck size > 15 in.*
Grinding sound in jaw joint	*Forehead headaches*	*Forward head posture (ears ahead of shoulders)*
Jaw clenching	*Injury to face*	*Injury to neck*
Jaw joint injury	*Migraine-type headaches*	*Lack of mobility*
Jaw joint pain	*Morning headache*	*Lower jaw & chin bulge*

Jaw locks open/shut	*Scalp tender to touch*	*Male neck size > 17 in.*
Jaw pain	*Severe headaches*	*Neck, shoulder, and/or back pain*
Locking jaw joints	*Sinus Headaches*	*On-going chiropractic, cranio-sacral, or other body therapy*
Pain in cheek muscles	*Temporal headaches*	*Stiffness*
Sore jaws	*Tension Headaches*	*Tired/Sore neck muscles*
Uncontrollable jaw movement	Other (specify):	Other (specify):
When opening or closing mouth, jaw deviates or deflects from center line		

Ears	**Nasal**	**Eyes**
Balance problems	Allergies	Bloodshot eyes
Clogged/stuffy feeling in ears	*Post-nasal drainage*	*Blurred vision*
Decreased hearing	*Shortness of breath*	Dark circles under eyes
Ear pain without infection	*Sinus infection*	Glaucoma
Frequent ear infection	Sinus pain	Pain in/around/behind eyes
Hearing impairment	*Sinus problems*	Pressure behind eyes
Itchy feeling in ears	*Stuffy/runny nose, post-nasal drainage, or other sinus issues*	Sensitivity to light
Ringing/Buzzing in ears		Tearing of eyes
Tubes in ears		*Visible white space (sclera) under iris of eyes*
Sleep		
CPAP machine to sleep	*Insomnia*	*Sleep test diagnosed obstructive sleep apnea*
Daytime sleepiness/fatigue	*Lethargy / Feel unenergized after waking up in the morning and/or most times*	*Snoring/Snoring reported to you by others*
Gasping for air / choking in sleep	*Sleep apnea (suspected)*	*Trouble/Restless sleeping*

Please circle all that apply to you. Write in any important details as needed.

ADD/ADHD - hyperactive	
Adenoids removed	
Anemia	
Anxiety	
Arm/Finger pain/numbness	
Arteriosclerosis	
Asthma	
Autoimmune disorder	
Autoimmune disorder/disease (specify) -	
Bleed easily	
Bruise easily	
Cancer	
Chemotherapy	
Chronic fatigue	
Cold hands / cold feet	

Current pregnancy	
Depression	
Difficulty focusing	
Emphysema	
Epilepsy	
Erectile dysfunction	
Excessive thirst	
Fluid retention	
Foggy/Senile memory	
Frequent colds	
Frequent illness	
Frequent stress	
Gout	
Grouchiness/Bad mood	
Hair loss	
Hay fever	
Heart arrhythmia	
Heart disease	
Heart disorder	
Heart murmur	
Heart pacemaker	
Heart palpitations	
Heart valve replacement	
Hemophilia	
Hepatitis	
High blood pressure	
History of physical injury/trauma from accident/incident (specify) -	
HIV/AIDS	
Hypoglycemia	
Hypothyroidism	
Immune disorder	
Joint replacement	
Kidney problems	
Lack of coordination	
Liver disease	
Low blood pressure	
Low libido/sex drive	
Meniere's disease	
Mitral valve procedure	
Multiple sclerosis	
Muscle aches	
Muscle cramps	
Muscle tremors	
Muscular dystrophy	
Nervous irritability	
Nervousness	
Neuralgia	
Numbness of hands, feet, arms, and/or legs	

Osteoporosis	
Parkinson's disease	
PMS	
Poor circulation	
Pot belly	
Psychiatric care	
Radiation treatment	
Rheumatic fever	
Rheumatoid arthritis	
Scarlet fever	
Skin disorders	
Slow healing sores	
Stroke	
Swollen calf muscles	
Swollen joints	
Thyroid disease	
Tuberculosis	
Tumors	
Type 1 Diabetes	
Type 2 Diabetes	
Urinary disorders	
Waking up to urinate more than once	
Weight gain	

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 choose the most appropriate number for each situation.

SITUATION (*check ☑ the box*)	**No chance of dozing**	**Slight chance of dozing**	**Moderate chance of dozing**	**High chance of dozing**
Sitting and reading	☐ (0)	☐ (1)	☐ (2)	☐ (3)
Watching TV or a movie	☐ (0)	☐ (1)	☐ (2)	☐ (3)
Sitting inactive in a public space (e.g. theater, meeting, park, etc.)	☐ (0)	☐ (1)	☐ (2)	☐ (3)
As a passenger in a car for an hour without a break	☐ (0)	☐ (1)	☐ (2)	☐ (3)
Lying down to rest in the afternoon when circumstances permit	☐ (0)	☐ (1)	☐ (2)	☐ (3)
Sitting and talking to someone	☐ (0)	☐ (1)	☐ (2)	☐ (3)

Sitting quietly after a lunch without alcohol	☐ (0)	☐ (1)	☐ (2)	☐ (3)
In a vehicle, while stopped for a few minutes in traffic	☐ (0)	☐ (1)	☐ (2)	☐ (3)

Internal Use Only:

Total Points Epworth Sleepiness Scale = _____

1 to 6 = sufficient sleep
7 to 8 = average
9 and up = sleep specialist referral

*****You may write in any additional information, medications, supplements, and/or allergies and specifics below.**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for completing your information! We look forward to helping you achieve your total wellness goals!

I certify that the above information and health history update is true and correct to the best of my knowledge.

_____
Name (Printed)

_____ _____
Signature **Today's Date**