Skale Dental Professionals
Darryl A. Skale, DDS | Ryan L. Skale, DDS

MEDICAL HISTORY

Patient's Name: _____ Birth Date: _____

1. Has there been any change in your general health within the past year? If yes, for what reason? _____	YES	NO
2. Are you now under the care of a physician or health care professional? If yes, for what reason? _____ Physician's Name: _____ Phone: _____	YES	NO
3. Have you had any serious illness, operation, or been hospitalized in the past five years? If yes, for what reason? _____	YES	NO
4. Do you have, or have you ever had any of the following. (check all that apply) ☐ Heart disease/ surgery ☐ Heavy snoring ☐ Eating disorder (any form) ☐ Heart attack ☐ Affects sleep of others ☐ Recreational drug use ☐ Chest pain ☐ Daytime sleepiness ☐ Alcoholism ☐ Congenital heart disease ☐ Sleep apnea & CPAP ☐ Drug addiction ☐ Heart murmur ☐ Sinus trouble ☐ Hepatitis (any form) ☐ Mitral valve prolapse ☐ Hay fever/ allergies/ hives ☐ Liver disease ☐ Artificial heart valve ☐ Latex sensitivity ☐ Cancer or tumors ☐ Heart pacemaker ☐ Chronic cough ☐ Chemotherapy ☐ Tuberculosis (TB) ☐ Shortness of breath ☐ Radiation therapy ☐ Stroke ☐ Tobacco use ☐ Thyroid problems ☐ Diabetes ☐ Emphysema ☐ Glaucoma ☐ Arthritis/ rheumatism ☐ Asthma ☐ HIV positive ☐ Cortisone medication ☐ Anemia ☐ AIDS ☐ Oral bisphosphate medication ☐ Sickle cell disease ☐ Venereal disease (STD's), HPV ☐ Artificial joint (any type) ☐ Fainting or dizzy spells ☐ Cold sores ☐ Swollen ankles ☐ Epilepsy or seizures ☐ Kidney troubles ☐ Blood transfusion ☐ Anxiousness ☐ Ulcers ☐ Hemophilia ☐ Psychological care		
5. Do you have/ have you had any disease, condition, or problem not listed? If yes, please describe? _____	YES	NO
6. Can you get to sleep easily?	YES	NO
7. Can you stay asleep through the night?	YES	NO
8. Do you wake rested?	YES	NO
9. Have you lost or gained more than 10 pounds in the past year?	YES	NO
10. Are you allergic or have you experienced any reaction to the following? ☐ Penicillin ☐ Codeine or other narcotics ☐ Other _____ ☐ Sulpha drugs ☐ Latex	YES	NO
11. Are you currently taking any medication, pills, or herbs? If yes, please list (name and dosage): _____ _____	YES	NO
12. WOMEN ONLY: Are you pregnant?	YES	NO
13. WOMEN ONLY: Do you take oral contraceptives?	YES	NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of changes in my medical history.

x _____

Signature of Responsible Party *Relationship (if minor)* *Date*

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DENTAL HISTORY

Patient's Name:_____ Birth Date:_____

14. What is the reason for your visit today?_____

15. Date of Last Dental Visit:_____ Last Dental Cleaning:_____

Previous Dentistôs Name: _____ Phone:_____

16. How often do you brush your teeth?_____ Floss?_____

17. What other dental aids do you use? (Waterpik, toothpick, etc.)

_____

18. Do you currently have any dental problems? If yes, please describe: _____	YES	NO
19. Does dental treatment make you nervous?	YES	NO
20. Are you satisfied with the appearance of your smile?	YES	NO

21. Have you ever been treated with:
☐ Orthodontics ☐ Braces ☐ Invisalign

22. Are your teeth sensitive to:
☐ Hot or cold ☐ Sweets ☐ Biting or chewing

23. Do your gums bleed or hurt?	YES	NO
24. Have you noticed any broken fillings, loose teeth, or change in your bite?	YES	NO
25. Have you had a serious injury to your head or mouth?	YES	NO

26. Have you ever experienced any of the following:

			YES	NO
☐ Clicking or popping of your jaw	☐ Range of motion problems	☐ Difficulty in opening or closing		
☐ Jaw pain	☐ Locking of the jaw	☐ Difficulty in chewing		
☐ Face pain	☐ Limited mouth opening	☐ Other:		

27. Do you get headaches often?	YES	NO
28. Do you clench or grind your teeth?	YES	NO
29. Do you smoke or use chew tobacco?	YES	NO
30. Is there anything else about having dental treatment that you would like us to know? If yes, please describe: _____	YES	NO

I understand the above information is necessary to provide me *with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of changes in my dental history.*

X _____

Signature of Responsible Party *Relationship (if minor)* *Date*

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1220 Meadow Road, Suite 202
Northbrook, IL 60062

Patient Information

Last Name: _____ First Name: _____ MI: _____

Birthdate: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Employer: _____

Email: _____

☐ I would like to opt out of email reminders.

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Responsible Party or Primary Insurance Subscriber (if other than patient above)

Last Name: _____ First Name: _____ MI: _____

Birthdate: _____ Relationship to Patient: _____

SS#: _____ Cell Phone: _____

Employer: _____

(If not the same as patient above)

Address: _____

City: _____ State: _____ Zip: _____

STOP BANG QUESTIONNAIRE

Height _____ inches/ cm Weight _____ lbs/ kg

Age _____

Gender: Male Female

Collar size of shirt: S M L XL, or _____ inches/ cm

Neck circumference _____ cm

1. Snoring

   Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
   YES NO

2. Tired

   Do you often feel tired, fatigued, or sleepy during daytime?
   YES NO

3. Blood pressure

   Do you have or are you being treated for high blood pressure?
   YES NO

4. BMI

   BMI more than 35 kg/ m^2?
   YES NO

5. Age

   Age over 50 years old?
   YES NO

6. Neck circumference greater than 15.7 inches?
   YES NO I do not know.

7. Gender

   Gender male?
   YES NO

Adapted from: STOP Questionnaire
A Tool to Screen Patients for Obstructive Sleep Apnea

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Patient's Acknowledgement of Receipt of Notice of Privacy Rules

I have read a copy of the Notice of the Privacy Practices of the office of Skale Dental Professionals.

(If you would like to read this, please request to do so at the front desk.)

Last Name (please print): _____

Signature: _____

Date: _____

If you have consented for a minor (above):

Last Name (please print): _____

Signature: _____

Date: _____

If you are 18 or older and on your parentsôinsurance policy or not financially responsible:

Please sign below to give authorization for protected healthcare information to be discussed with your parents or financially responsible party.

X _____ Date: _____

OPTING OUT

- ☐ I do not want appointment reminder messages left on my home answering system.
- ☐ I do not wish my protected health care information to be released to the following person:

  _____

- ☐ I decline to sign the acknowledgement.

  _____

OFFICE USE: The office was unable to obtain a signed Acknowledgement form from the above patient for the following reason: