

**Steve Marinkovich, D.D.S.**

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Please Print

Med Rec. # \_\_\_\_\_  
Name \_\_\_\_\_  
Birth date \_\_\_\_\_  
Age \_\_\_\_\_ Sex M/F

Date \_\_\_\_\_  
Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient Address: - Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Patient Phone Number: \_\_\_\_\_

Height \_\_\_\_\_ Current Weight \_\_\_\_\_ Weight 5 years ago \_\_\_\_\_ Peak Lifetime Weight \_\_\_\_\_

Martial Status: Single Married Divorced Widowed Separated

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**PATIENT PROBLEM** Briefly describe the problem with your sleep as you see it:

**PATIENT EXPECTATION** What is the nature of assistance you expect or desire?

**Client History**

Yes No Have you been evaluated at a sleep disorders center before?  
If yes, when (date) \_\_\_\_\_ Where? \_\_\_\_\_  
What were you told the problem was? \_\_\_\_\_

What treatment were you given? \_\_\_\_\_  
Why are you being evaluated again? \_\_\_\_\_

Yes No Do you have your last meal of the day within two hours of bedtime?  
Yes No Do you have a problem with heartburn (GERD) on a regular basis?

**Tobacco**

Yes No Do you smoke tobacco?  
If yes, how much per day? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_

Yes No If you smoke tobacco, do you smoke when you wake up during the night?  
Yes No If you smoke tobacco, have you noticed that nicotine alters or interferes with your sleep?

**Beverages**

Yes No Do you usually drink coffee, tea, chocolate, cola or other caffeinated beverages within 3 hours of your bedtime?

How much of the following do you drink in a usual day?

Coffee/Tea \_\_\_\_\_ Cola \_\_\_\_\_ Chocolate \_\_\_\_\_ Other \_\_\_\_\_

Yes No Do you drink alcoholic beverages?

Assuming the following drinks are equivalent-12 oz. beer/5 oz. wine/3 oz. whiskey, gin, or vodka—then:

How many drinks do you have in a usual weekday? \_\_\_\_\_ On a weekend or holiday? \_\_\_\_\_

Yes No Do you drink alcohol within two hours of bedtime?

Yes No Do alcoholic beverages alter or interfere with your sleep?

Yes No Have you ever used alcohol in order to get to sleep?

Yes No Have you ever sought treatment/ counseling for an alcohol problem?

**Epworth Sleepiness Scale**

How likely are you to doze off or fall asleep in the following circumstances, 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. Using the scale below, circle the most appropriate number for each situation and add up your total score.

	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place ( i.e. a theatre)	0	1	2	3
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 car while stopped for a few minutes in traffic	0	1	2	3
Total				
Quality of sleep: ?poor ?average ?good				
Additional comments: ( i.e. Alcohol consumption, sleep medication, indicate CPAP pressure for follow up study, etc.)				

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Please fill out completely

*REVIEW OF SYSTEMS/PAST MEDICAL HISTORY*

<b>Do you currently have any of the following?</b>				<b>Past History</b>			
<b>General</b>	Tire easily	Yes	No	Have you ever had any of the following?			Year
	Marked weight change	Yes	No	Measles	Yes	No	_____
	Night sweats	Yes	No	Mumps	Yes	No	_____
	Persistent fever	Yes	No	Infections Mononucleosis	Yes	No	_____
	Sensitivity to heat or cold	Yes	No	Tuberculosis	Yes	No	_____
<b>Skin</b>	Rashes	Yes	No	Pneumonia/Pulmonary Disease	Yes	No	_____
	Change in hair or nails	Yes	No	Asthma	Yes	No	_____
<b>Eyes</b>	Change in the vision, double vision			Hepatitis/Liver Disease	Yes	No	_____
	Change in hearing	Yes	No	Rheumatic Fever	Yes	No	_____
	Ringing in ears	Yes	No	Kidney disease	Yes	No	_____
	Discharge	Yes	No	Arthritis	Yes	No	_____
<b>Nose</b>	Change of smell	Yes	No	High blood pressure	Yes	No	_____
	Obstruction	Yes	No	Bleeding tendency	Yes	No	_____
	Excessive discharge	Yes	No	Cancer	Yes	No	_____
	Bleeding	Yes	No	Diabetes	Yes	No	_____
	Sinus infections or CAT scan	Yes	No	Heart disease	Yes	No	_____
<b>Mouth</b>	Sore gums or tongue	Yes	No	HIV/Aids	Yes	No	_____
	Lumps or ulcers	Yes	No	Any other illnesses:	_____		_____
<b>Throat</b>	Soreness	Yes	No	<b>Operations</b>			
	Hoarseness	Yes	No	Tonsillectomy	Yes	No	Year
<b>Heart and Lungs</b>							
	Cough-persistent	Yes	No	Appendectomy	Yes	No	_____
	Yellow or green sputum	Yes	No	Gall Bladder	Yes	No	_____
	Bloody sputum	Yes	No	Nasal	Yes	No	_____
	Wheezing	Yes	No	Heart	Yes	No	_____
	Chest pain/tightness	Yes	No	Thyroid	Yes	No	_____
	Difficulty breathing lying down	Yes	No	Ears	Yes	No	_____
	Swelling of ankles	Yes	No	Hernia	Yes	No	_____
	High blood pressure	Yes	No	Any other operations:	_____		_____
	Palpitations	Yes	No	<b>Allergies to Medications</b>			
<b>Digestive</b>						Reaction	
	Change in appetite	Yes	No	Penicillin	Yes	No	_____
	Difficulty swallowing	Yes	No	Sulfa	Yes	No	_____
	Heart burn	Yes	No	Foods	Yes	No	_____
	Abdominal pain	Yes	No	Adverse reaction to anesthesia	Yes	No	_____
	Nausea	Yes	No	Any other drugs	_____		_____
	Vomiting	Yes	No	<b>Personal Habits-Dependencies</b>			
	Change in stools	Yes	No	Caffeine	Yes	No	_____
	Jaundice	Yes	No	Alcohol	Yes	No	_____
<b>Endocrine</b>				Tobacco	Yes	No	_____
	Thyroid trouble	Yes	No	Non-prescribed drugs	Yes	No	_____
	Adrenal trouble	Yes	No	<b>Family History</b>			
	Cortisone treatments	Yes	No	Has any blood relative had any of the following?			
	Are you nursing a baby?	Yes	No	Anemia	Yes	No	Relationship
<b>Genitourinary</b>							
	Increase frequency of urination	Yes	No	Bleeding tendency	Yes	No	_____
	Nighttime urination	Yes	No	Leukemia	Yes	No	_____

**Continued on Next Page**

**Personal History Continued**

Could you be pregnant?	Yes	No
Lack of sex drive?	Yes	No
Locomotor		
Muscle cramps	Yes	No
Pain in Joints	Yes	No
Swelling in Joints	Yes	No
Stiffness	Yes	No
Nervous systems	Yes	No
Headaches	Yes	No
Dizziness	Yes	No
Fainting	Yes	No
Memory Loss	Yes	No
Convulsions	Yes	No
Sleepwellness	Yes	No
Poor Condition	Yes	No
Muscle weakness or paralysis	Yes	No

**Family History Continued**

Repeated infections	Yes	No	_____
Heart disease	Yes	No	_____
Chronic lung disease	Yes	No	_____
Asthma	Yes	No	_____
High blood pressure	Yes	No	_____
Severe allergies	Yes	No	_____
Migraine headaches	Yes	No	_____
Diabetes	Yes	No	_____
Cancer	Yes	No	_____
Obesity	Yes	No	_____
Thyroid trouble	Yes	No	_____
Hearing loss	Yes	No	_____
Mental illness	Yes	No	_____
Work History			
Current and past occupations			_____
			_____
			_____

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_