### Medical Evaluation

#### Airway Management

Height: _________  Weight: _________  BMI:________  Blood Pressure: ________________  Neck Size (Inches):________

Please check any of the following you may have (or suffer from):

- ❏ Morning Headaches
- ❏ Heart Disease
- ❏ Insomnia
- ❏ Diabetes
- ❏ Heart Failure
- ❏ Frequent Urination at Night
- ❏ ADD/ADHD
- ❏ Depression
- ❏ Dry Mouth
- ❏ Renal Failure
- ❏ Erectile Dysfunction
- ❏ Fibromyalgia
- ❏ Obesity
- ❏ Memory Loss
- ❏ Low Testosterone
- ❏ Grinding Teeth (Bruxism)
- ❏ Restless Legs (RLS)
- ❏ COPD
- ❏ GERD
- ❏ Atrial Fibrillation

Please check Yes or No to the following questions:

1. Do you snore or have been told that you snore?  No ❏ Yes ❑
2. Do you often feel tired, fatigued, or sleepy during the daytime?  No ❏ Yes ❑
3. Has anyone observed you stop breathing or gasp for air during your sleep?  No ❏ Yes ❑
4. Do you have or are you being treated for high blood pressure?  No ❏ Yes ❑

Please check the following appropriate boxes:

<table>
<thead>
<tr>
<th>Epworth Sleepiness Scale</th>
<th>Never doze off</th>
<th>Slight chance of dozing</th>
<th>Moderate chance of dozing</th>
<th>High Chance of dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you get sleepy, or doze off, while sitting and reading?</td>
<td>0 ❏</td>
<td>1 ❚</td>
<td>2 ❚</td>
<td>3 ❚</td>
</tr>
<tr>
<td>2. Do you get sleepy, or doze off, while watching TV?</td>
<td>0 ❏</td>
<td>1 ❚</td>
<td>2 ❚</td>
<td>3 ❚</td>
</tr>
<tr>
<td>3. While sitting or inactive in a public place?</td>
<td>0 ❏</td>
<td>1 ❚</td>
<td>2 ❚</td>
<td>3 ❚</td>
</tr>
<tr>
<td>4. As a passenger in a car for an hour without a break?</td>
<td>0 ❏</td>
<td>1 ❚</td>
<td>2 ❚</td>
<td>3 ❚</td>
</tr>
<tr>
<td>5. Lying down to rest in the afternoon?</td>
<td>0 ❏</td>
<td>1 ❚</td>
<td>2 ❚</td>
<td>3 ❚</td>
</tr>
<tr>
<td>6. Sitting and talking to someone?</td>
<td>0 ❏</td>
<td>1 ❚</td>
<td>2 ❚</td>
<td>3 ❚</td>
</tr>
<tr>
<td>7. Sitting quietly after lunch without alcohol?</td>
<td>0 ❏</td>
<td>1 ❚</td>
<td>2 ❚</td>
<td>3 ❚</td>
</tr>
<tr>
<td>8. In a car, while stopped for a few minutes at a traffic light?</td>
<td>0 ❏</td>
<td>1 ❚</td>
<td>2 ❚</td>
<td>3 ❚</td>
</tr>
</tbody>
</table>

Total Score

Have you ever been diagnosed with sleep apnea?  No ❏ Yes ❑
Are you currently using CPAP? (or any other apnea/snoring device)  No ❏ Yes ❑
Are you currently taking any sleeping aids (prescribed or OTC)?  No ❏ Yes ❑
Are you currently taking any prescribed pain medication?  No ❏ Yes ❑

### Oral Cancer

Please check the following appropriate boxes

1. Have you ever been diagnosed or have a family history of Oral Cancer?  No ❏ Yes ❑
2. Have you ever been diagnosed or have a family history HPV?  No ❏ Yes ❑
3. Do you currently use any tobacco products, or have used them in the past?  No ❏ Yes ❑
4. Do you use e-cigarettes or do you use vapor devices?  No ❏ Yes ❑
5. Do you regularly consume alcoholic beverages?  No ❏ Yes ❑