*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? | ☐ YES | ☐ NO |
| 2. Do you often feel tired, fatigued, or sleepy during the daytime? | ☐ YES | ☐ NO |
| 3. Has anyone observed you stop breathing or gasp for air during your sleep? | ☐ YES | ☐ NO |
| 4. Do you have or are you being treated for high blood pressure? | ☐ YES | ☐ NO |

Please check the following appropriate boxes:

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

| | | |
|---|---|---|
| Have you ever been diagnosed with sleep apnea? | ☐ YES | ☐ NO |
| Are you currently using CPAP? (or any other apnea/snoring device) | ☐ YES | ☐ NO |
| Are you currently taking any sleeping aids (prescribed or OTC)? | ☐ YES | ☐ NO |
| Are you currently taking any prescribed pain medication? | ☐ YES | ☐ NO |

# Oral Cancer

| Please check the following appropriate boxes | | |
|---|---|---|
| 1. Have you ever been diagnosed or have a family history of Oral Cancer? | ☐ YES | ☐ NO |
| 2. Have you ever been diagnosed or have a family history **HPV**? | ☐ YES | ☐ NO |
| 3. Do you currently use any tobacco products, or have used them in the past? | ☐ YES | ☐ NO |
| 4. Do you use e-cigarettes or do you use vapor devices? | ☐ YES | ☐ NO |
| 5. Do you regularly consume alcoholic beverages? | ☐ YES | ☐ NO |