Medical Evaluation

Oral Cancer / Airway Management

Today's Date:_____

Patient Name:_____ Date of Birth:_____

Primary Medical Provider:_____ Phone:_____

Other Medical Provider(s):_____

Oral Cancer Evaluation

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

Medical History / Review of Systems

☐ **Morning Headaches**	☐ **Heart Disease**	☐ **Heart Failure**	☐ **Diabetes**	☐ **Insomnia**
☐ **Frequent Urination at Night**	☐ **ADD/ADHD**	☐ **Renal Failure**	☐ **Dry Mouth**	☐ **Depression**
☐ **Jaw Discomfort**	☐ **Fibromyalgia**	☐ **Low Testosterone**	☐ **Memory Loss**	☐ **Snoring**
☐ **Grinding Teeth (Bruxism)**	☐ **Restless Legs (RLS)**	☐ **Atrial Fibrillation**	☐ **Night Sweats**	☐ **COPD**
☐ **Fatigue/Hypersomnia** (excessive daytime sleepiness)	☐ **Restless Sleep**	☐ **Obesity/Overweight**	☐ **Hypertension** (high blood pressure)	☐ **GERD** (acid reflux)

OSA / Airway Evaluation

1. Do you snore *or* have been told that you snore?	☐ YES	☐ NO	☐ NOT SURE
2. Do you often feel tired, fatigued, or sleepy during the daytime?	☐ YES	☐ NO	☐ NOT SURE
3. Has anyone observed you stop breathing or gasping for air during your sleep?	☐ YES	☐ NO	☐ NOT SURE
4. Do you have or are you being treated for high blood pressure or GERD (acid reflux)?	☐ YES	☐ NO	☐ NOT SURE

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/had a sleep study?	☐ 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

Physical Evaluation- OFFICE USE ONLY

Gender:_____ **Height:**_____ **Weight:**_____ **BMI:**_____ **Blood Pressure:**_____

Neck Circumference:_____inches **Mallampati Score/Class:** 1 2 3 4

☐ **Enlarged/Scalloped Tongue** ☐ **Retruded Lower Jaw** ☐ **High Arching Hard Palate** ☐ **Enlarged Tonsils**

Provider Signature/Initials*_____

*To be filed for reference and review in patient's chart notes