Pecan Park Dental

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Airway Acessment/Oral Cancer Screening

Patient Name:_____ Date Of Birth: _____
Gender:_____ Height:_____ Weight:_____Blood Pressure:_____ Neck Circumference: _____
Primary Care Physican: _____ Office Phone: _____
Address: _____

Airway Management

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

- ☐ Morning Headaches
- ☐ Jaw Discomfort
- ☐ Fatigue/Hyersomnia (excessive daytime sleepiness)
- ☐ Add/Adhd
- ☐ Obesity/Overweight
- ☐ Dry Mouth
- ☐ Nights Sweats
- ☐ Insomnia
- ☐ Snorning
- ☐ GERD(acid reflux)
- ☐ Restless Leg (RLS)
- ☐ Heart Failure
- ☐ Low Testosterone
- ☐ Frequent Urination at night
- ☐ Grinding Teeth(Bruxium)
- ☐ Heart Disease
- ☐ Atrial Fibrillation
- ☐ Diabetes
- ☐ Memory Loss
- ☐ Hypertension(high blood pressure)
- ☐ Depression
- ☐ COPD
- ☐ Fibromyalgia
- ☐ Restless Sleep
- ☐ Renel Failure

Please check YES or No to the following questions:

Do you snore or have been told that you snore? ◯ Yes ◯ No

Do you often feel tired**,fatigued,or sleepy during the daytime?** ◯ Yes ◯ No

Has anyone observed you STOP breathing or gasp for air during your sleep? ◯ Yes ◯ No

Do you have or are you being treated for high blood pressure or GERD (acid reflux) ◯ Yes ◯ No

Please check the following appropriate boxes:

Do you get sleepy, or doze off, while sitting and reading?

◯ Never Doze 0 ◯ Slight chance of doze 1 ◯ Moderate chance of dozing 2 ◯ High chance of dozing 3

Do you get sleepy, or doze off , while watching TV?

◯ Never Doze 0 ◯ Slight chance of doze 1 ◯ Moderate chance of dozing 2 ◯ High chance of dozing 3

While sitting or inactive in the public place?

◯ Never Doze 0 ◯ Slight chance of doze 1 ◯ Moderate chance of dozing 2 ◯ High chance of dozing 3

As a passenger in a car for an hour without a break?

◯ Never Doze 0 ◯ Slight chance of doze 1 ◯ Moderate chance of dozing 2 ◯ High chance of dozing 3

Lying down to rest in the afternoon?

◯ Never Doze 0 ◯ Slight chance of doze 1 ◯ Moderate chance of dozing 2 ◯ High chance of dozing 3

Sitting and talking to someone?

◯ Never Doze 0 ◯ Slight chance of doze 1 ◯ Moderate chance of dozing 2 ◯ High chance of dozing 3

Sitting quietly after lunch without alcohol?

◯ Never Doze 0 ◯ Slight chance of doze 1 ◯ Moderate chance of dozing 2 ◯ High chance of dozing 3

In a car, while stopped for a few minutes at traffic lights?

◯ Never Doze 0 ◯ Slight chance of doze 1 ◯ Moderate chance of dozing 2 ◯ High chance of dozing 3

Oral Cancer

Have you ever been diagnosed or have a family member of oral cancer? ◯ Yes ◯ No

Have you ever been diagnosed or have a family history of HPV? ◯ Yes ◯ No

Do you currently use any tabacco products, or have used them in the past? ◯ Yes ◯ No

Do you use e-cigarettes or do you use vapor devies? ◯ Yes ◯ No

Do you regularly consume alcholic beverages? ◯ Yes ◯ No

Patient Signature: _____

Response Date: ____/____/_____