DONNA BEHR LLC
PHYSICAL THERAPY

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MEDICAL HISTORY – ADDITIONAL INFORMATION

Patient Name _____ Date of Birth _____

VISUAL HISTORY

Do you wear contacts? Yes No; If yes, what is your prescription?_____

Do you wear eyeglasses? Yes No; If yes, what is your prescription? _____

Have you ever had Lasik? Yes No

Have you ever had cataract surgery? Yes No

Are you in monovision? Yes No

Were you ever diagnosed with a "lazy eye", amblyopia, or strabismus? Yes No

Do you ever experience double vision? Yes No

Do you have any degenerative eye conditions such as glaucoma or macular degeneration? Yes No

If yes, please list _____

DENTAL HISTORY

Have you ever had orthodontia such as braces or Invisalign? Yes No; If yes, what kind? _____

Have you ever had any tooth extractions? Yes No; If yes, which ones? _____

Are you currently missing any teeth? Yes No

Do you wear any dentures or bridges? Yes No

Do you have a history of clenching or grinding your teeth? Yes No

Have you ever been prescribed a nightguard? Yes No; If yes, do you currently wear one? Yes No

Please describe any other significant dental history: _____

SLEEP HISTORY

What time do you typically go to bed? _____ Do you have trouble falling asleep? _____

What time do you typically wake up in the morning? _____

Do you sleep through the night without waking? Yes No; If no, how many times do you wake up? _____

When you wake up in the morning do you feel refreshed? Yes No

Do you snore? Yes No

What position do you sleep in? Back, Side, Stomach, Shift around

Have you ever been diagnosed with obstructive sleep apnea? Yes No; If yes, how are you currently managing it? _____

GASTROINTESTINAL HISTORY

Please list any gastrointestinal concerns/issues you have: