Medical Alert:

PATIENT

REASON FOR TODAYS VISIT: ____________________

(PLEASE PRINT) Mr./Mrs./Ms. (Circle one) Male _______ Female _______

PATIENT NAME: FIRST ____________________ MI ____ LAST ____________________ DOB ____________

ADDRESS ______________________________ CITY ______________ STATE _______ ZIP __________

HOME PHONE (___)______________ WORK PHONE (___)______________ SSN #________ - ________ - ________

E-MAIL ______________________________ EMPLOYER ______________________________

NAME OF PHYSICIAN & PHONE NO ______________________________ DATE OF LAST PHYSICAL ______

IN CASE OF EMERGENCY CONTACT ______________________________ ***PHONE*** ______________

DO YOU HAVE A HISTORY OF:

	YES	NO		YES	NO		YES	NO		YES	NO
A.I.D.S/HIV Positive	❑	❑	Excessive Bleeding	❑	❑	Low Blood Pressure	❑	❑	Stroke	❑	❑
Alcoholism	❑	❑	Frequent Headaches	❑	❑	Malignancies	❑	❑	Tuberculosis	❑	❑
Allergies	❑	❑	Hearing Impaired	❑	❑	Neck & Back Problems	❑	❑	Ulcers	❑	❑
Anemia	❑	❑	Heart Disease	❑	❑	Nervous Problems	❑	❑	Venereal Disease	❑	❑
Arthritis	❑	❑	Heart Valve, Murmur	❑	❑	Pacemaker	❑	❑	Bone Disease	❑	❑
Asthma	❑	❑	Hepatitis/Liver Disease	❑	❑	Prosthetic Joints	❑	❑	Epilepsy	❑	❑
Cancer	❑	❑	Hepatitis Carrier	❑	❑	Psychiatric Care	❑	❑	Thyroid Disease	❑	❑
Chemical Dependency	❑	❑	High Blood Pressure	❑	❑	Radiation Treatments	❑	❑			
Chest Pain	❑	❑	Kidney Disease	❑	❑	Respiratory Problems	❑	❑	Are there any problems not listed you would like to discuss?	❑	❑
Circulatory Problems	❑	❑	Kidney Dialysis	❑	❑	Rheumatic Fever	❑	❑			
Convulsions/Seizures	❑	❑	Latex Sensitivity	❑	❑	Scarlet Fever	❑	❑			
Diabetes	❑	❑	Lupus	❑	❑	Sinus Problems	❑	❑			

List any medications you are taking including non-prescription drugs

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Are you allergic to any medications?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

DENTAL INFORMATION

1. Date of last dental visit: ______________________
2. If wearing dentures, age of dentures: ______________________

	YES	NO
3. Do your gums bleed when brushing or eating?	❑	❑
4. Do you ever clench or grind your teeth?	❑	❑
5. Are your teeth sensitive to hot, cold or pressure?	❑	❑

WOMEN	**YES**	**NO**
Is there a possibility of pregnancy?	❑	❑
Estimated delivery date ____/____/____	❑	❑
Are you nursing?	❑	❑
Are you taking birth control pills?	❑	❑

WOMEN NOTE: *Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynocologist for assistance regarding additional methods of birth control.*

On a scale of 1 to 10 with 10 being the highest rating:
How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

If I could change my smile I would make my teeth:	YES	NO
Whiter	❑	❑
Straighter	❑	❑
Close space	❑	❑
Replace black mercury fillings with tooth colored restorations	❑	❑
Repair chipped teeth	❑	❑
Replace missing teeth	❑	❑
Less gum showing	❑	❑
Replace old crowns or caps that don't match	❑	❑
Do you prefer to save your teeth?	❑	❑

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors that I have made in the completion of this form.

Signature of Patient (parent or guardian if minor): ______________________________ Date ______________

Health History Reviewed by: ______________________ Dentist Signature: ______________________

TMJ HEALTH QUESTIONNAIRE

Date ______________

CHIEF CONCERN ______________________________
DATE OF ONSET ______________________________

PAIN SYMPTOMS

Do you get headaches? Y N
Do you get migraine headaches? Y N
Do you frequently have neck aches or stiff neck muscles? Y N
Have you ever had chronic shoulder or back pain? Y N
Do you have trouble sleeping soundly? Y N
Are your jaws tired when you awaken? Y N
Are your teeth sore when you awaken? Y N

Have your wisdom teeth been extracted? Y N

What medications, if any, are you taking?

____

Do you get headaches in the right or left temple areas? Y N
Do you get headaches in the front or back of your head? Y N
Do you clench your teeth during the day? Y N
Do you clench your teeth at night? Y N
Do you grind your teeth when asleep? Y N

When are your pain symptoms the worst?

____

Does anything make you feel better?

____

How often do you take medication for relief of pain?

____

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw? Y N
Any whiplash neck injuries? Y N

Have you ever been involved in any serious accidents, such as a car accident? Y N
Details ______________________________

____

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal? Y N
Are there any foods you avoid eating? Y N
Do you ever get dizzy? Y N
Do you ever feel faint? Y N
Do you ever feel nauseated? Y N
Is there a family history of jaw joint (TMJ) problems or headaches? Y N

Do you feel or hear a 'clicking', 'popping' or 'cracking' noise from either jaw joint? Y N
Has your jaw ever locked when you were unable to open or close? Y N
Do you have difficulty opening wide or yawning? Y N
Have you ever had pain in either jaw joint? Y N
Does your jaw ache when you open wide? Y N

EAR AND EYE SYMPTOMS

Do you have pain in either ear? Y N
Do you suffer from any loss of hearing? Y N
Do you have itchiness or stuffiness in either ear? Y N
Do you hear ringing, buzzing, or hissing sounds in either ear? Y N

Do you wear glasses or contacts? Y N
Are there times when your eyesight blurs? Y N
Do you get pain in, around or behind either eye? Y N

BREATHING

Do you have allergies? Y N
Do you have sinus problems? Y N
Do you snore at night? Y N

Is your nose stuffed when you don't have a cold? Y N
Have you been diagnosed with Sleep Apnea? Y N
Have you had a sleep study done at a Sleep Clinic (hospital)? Y N