



Name of Medical Doctor: _____ City: _____ Phone: () _____

Date of last medical Exam: _____ (Female only) Is there any possibility you are pregnant? No Yes ___Months

Have you even had or do you have any of the following? Please check below.

- Heart murmur, Rheumatic fever, Mitral Valve Prolapse, Prosthetic joints / Heart Valves, Pacemaker, Heart problems, High Blood Pressure, Stroke, when, Blood trouble, anemia, leukemia, Excessive bleeding, Hepatitis: A or B or C or other, Diabetes: Type I or Type II, Tired jaw muscles, Dizziness/Loss of Balance, Earaches, Ringing in ears, Ear stuffiness, Jaw pain, Neck pain, Headaches/Facial Pain, Clenching/Grinding, Change in bite, Jaw locking/catching, Jaw clicking/popping, Lung trouble (TB, asthma, emphysema), Kidney disease, Arthritis, Degenerative joint disease, Fainting spells, epilepsy, convulsions, Nervous breakdown/ anxiety disorders, Indium, cobalt or Lithium treatment, Radiation or chemotherapy, Tumor or cancer, Shortness of Breath, Venereal disease, AIDS related complex, Other

Are you now taking medicines for: (please specify medication)

Have you ever been allergic to, been sick from, or been told not to take:

- Pain, Headaches, Arthritis, Allergy (asthma), Stomach (ulcers), Thyroid, Other, Heart, Nerves, Sleeping, Blood (thinners), GERD, Birth Control, Latex, Metals, Antibiotics (Penicillin, other), Narcotics (Codeine, other), Aspirin, NSAIDS, Anesthetics (Novocaine, other), Other medications

Do you have any disease conditions, or problems that are not mentioned above? _____

Do you smoke? No Yes If yes, how many cigarettes a day? _____ How many years? _____

Have you ever taken the diet drug combination, Fen-Phen? No Yes other diet drugs? _____

Referring Doctor's Name: _____ City: _____

Have you ever had or do you have any of the following?

What is the reason you are seeking TMJ care now?

- Orthodontic treatment, Dental extractions, Periodontal treatment, Gum surgery, Dental implants, Gum disease, Endodontics/Root canals, Mouth guards/Sports guards, Night guards, Teeth whitening, Sleep dentistry/general anesthesia/laughing gas, Fear or anxiety related to dental treatment, Jaw Pain, Closed Lock, Open Lock, Reduced/Deviated Range of Motion, Popping/Clicking, Headaches, Stiffness/Tinnitus, Other, What is your perceived level of pain/discomfort you are having now? None, Mild, Moderate, Severe, Have you gone anywhere else for your TMJ care? Yes, No, Are you undergoing any Dental care currently? Yes, No

I, the undersigned, have given the above information, have reviewed it and find it accurate. If there are any later changes, I will so inform the practice.

Patient Signature: _____ Date: _____

Patient Name (please print): _____