

Health History

(Please fill in completely)

Name: _____

Date: _____

Does your jaw now or has it ever made any noises, i.e. clicking, popping, etc.?

yes no

If so, please indicate which side(s).

both right left

Have you received treatment for any TMJ related or facial pain symptoms?

yes no

If so, where and when? _____

Please check any of the following you have or have had:

- | | |
|--|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> High blood pressure (hypertension) |
| <input type="checkbox"/> Allergies (environmental) | <input type="checkbox"/> High cholesterol (hypercholesterolemia) |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Joint replacement (please indicate where) _____ |
| <input type="checkbox"/> ___ osteo ___ rheumatoid ___ psoriatic | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Cancer (if so, state type) | <input type="checkbox"/> Muscle disease |
| _____ | <input type="checkbox"/> Nerve disease |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Obstructive sleep apnea (OSA) <input type="checkbox"/> Use CPAP |
| <input type="checkbox"/> Clotting disorder | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Prosthetic implant |
| <input type="checkbox"/> Degenerative disc disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Diabetes I | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Diabetes II | <input type="checkbox"/> (Heavy) snoring |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> ___ hypothyroidism ___ hyperthyroidism |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Trigeminal neuralgia |
| <input type="checkbox"/> ___ migraine ___ tension-type | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Ulcers (stomach) |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Other |
| <input type="checkbox"/> <input type="checkbox"/> have Pacemaker | _____ |
| <input type="checkbox"/> Heart murmur | _____ |

Have you ever been hospitalized for any serious illness or accident? If so, please explain.

Have you ever had TMJ or jaw surgery? If so, please explain. _____

List any drug allergies you have _____

List any other allergies you have _____

(Women) Are you pregnant? If so, how far along are you?

Please indicate on the following page any medications you are currently taking.