

SECTION I: PATIENT QUESTIONNAIRE

Date: _____

Patient Name: _____

Address: _____

Phone: _____

Employer: _____

Employer Address: _____

Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: Male Female Married Single

Email Address: _____ Driver's License _____

Social Security #: _____

Name of Spouse: _____

Parents' Name (if child): _____

If patient is a student: School _____ Year/Grade _____

What are your specific complaints? List from most to least important.

1. _____
2. _____
3. _____
2. _____

When did you first experience the problem for which you are seeking help?

Date: _____

In order, list all physicians, therapists, or health care providers you have consulted for this problem: _____

In YOUR opinion, what initiated your present condition (chief complaint)?

What aspect of your condition concerns you most? _____

SYMPTOM CHECK LIST

Please check any of the following symptoms which apply to you (L= left; R= right)

Headaches:

Migraines Tension Headaches Other _____

How often? _____

Top of Head	<input type="checkbox"/> L <input type="checkbox"/> R	Facial pain (non-specific)	<input type="checkbox"/> L <input type="checkbox"/> R
Forehead	<input type="checkbox"/> L <input type="checkbox"/> R	Clicking/popping in joint	<input type="checkbox"/> L <input type="checkbox"/> R
Back of Head (occipital)	<input type="checkbox"/> L <input type="checkbox"/> R	Temples	<input type="checkbox"/> L <input type="checkbox"/> R
Pain in neck	<input type="checkbox"/> L <input type="checkbox"/> R	Behind Eyes	<input type="checkbox"/> L <input type="checkbox"/> R
Pain in ear	<input type="checkbox"/> L <input type="checkbox"/> R	Pain in shoulder	<input type="checkbox"/> L <input type="checkbox"/> R
Ear congestion	<input type="checkbox"/> L <input type="checkbox"/> R	Dizziness (Vertigo)	_____
Tinnitus (Ringing in Ear)	<input type="checkbox"/> L <input type="checkbox"/> R	Pain in jaw joint	<input type="checkbox"/> L <input type="checkbox"/> R
Facial muscle twitch	<input type="checkbox"/> No <input type="checkbox"/> Yes	Grating sound in joint	<input type="checkbox"/> L <input type="checkbox"/> R
Difficulty breathing	<input type="checkbox"/> No <input type="checkbox"/> Yes	Difficulty swallowing	<input type="checkbox"/> No <input type="checkbox"/> Yes
through nose	<input type="checkbox"/> No <input type="checkbox"/> Yes	Difficulty chewing	<input type="checkbox"/> No <input type="checkbox"/> Yes

Partial inability to open mouth No Yes Constant Specific

Loose teeth (specify) _____

OCCLUSAL HABITS (check those which apply):

<input type="checkbox"/> Clenching <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Grinding on Teeth <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Teeth hit in front first	<input type="checkbox"/> Cheek Biting
<input type="checkbox"/> Gum Chewing	<input type="checkbox"/> Pipe Smoking
<input type="checkbox"/> Pencil Biting	<input type="checkbox"/> Nail Biting
<input type="checkbox"/> OTHER: _____	

POSTURAL HABITS (check those which apply):

<input type="checkbox"/> Phone cradling	<input type="checkbox"/> Leans chin on hand
<input type="checkbox"/> TV Watching	<input type="checkbox"/> Heavy Lifting
<input type="checkbox"/> Other : _____	

Date of last complete Medical Exam? _____ Month _____ Year

Family Physician _____ Specialty _____

Phone _____ Diagnosis/Treatment: _____

Address _____

Comments _____

Family Dentist _____ Specialty _____

Phone _____ Diagnosis/Treatment: _____

Address _____

Comments _____

Weight _____ Height _____

----- **MEDICATIONS CURRENTLY TAKING** -----

Medication Quantity Reason

Please check those that apply:

Are you currently under medical treatment? __No __Yes

Explain: _____

- | | |
|---|---|
| <input type="checkbox"/> Do you smoke? | <input type="checkbox"/> Frequent thirst/urination? |
| <input type="checkbox"/> History of diabetes in your family? | <input type="checkbox"/> A nervous person? |
| <input type="checkbox"/> Do you take blood thinners or aspirin? | <input type="checkbox"/> Blood transfusion? |
| <input type="checkbox"/> Heart trouble? | <input type="checkbox"/> AIDS? |
| <input type="checkbox"/> Artificial joints or implants? | <input type="checkbox"/> HIV? |
| <input type="checkbox"/> High blood pressure? | <input type="checkbox"/> Contact lenses? |
| <input type="checkbox"/> Low blood pressure? | <input type="checkbox"/> Psychiatric care? |
| <input type="checkbox"/> Arthritis rheumatism? | <input type="checkbox"/> Hepatitis? |
| <input type="checkbox"/> Persistent cough? | <input type="checkbox"/> Liver disease? |
| <input type="checkbox"/> Epilepsy or seizures? | <input type="checkbox"/> Jaundice? |
| <input type="checkbox"/> Heart murmur? | <input type="checkbox"/> Diabetes? |
| <input type="checkbox"/> Rheumatic fever? | <input type="checkbox"/> Ulcers? |
| <input type="checkbox"/> Congenital heart lesions? | <input type="checkbox"/> Asthma? |
| <input type="checkbox"/> Artificial heart valve? | <input type="checkbox"/> Hay fever? |
| <input type="checkbox"/> Heart surgery? | <input type="checkbox"/> Sinus trouble? |
| <input type="checkbox"/> Hemophilia? | <input type="checkbox"/> Scarlet fever? |
| <input type="checkbox"/> Shortness of breath? | <input type="checkbox"/> Orthodontic treatment? |
| <input type="checkbox"/> Allergies or hives? | <input type="checkbox"/> Lightened your teeth before? |
| <input type="checkbox"/> Fainting or dizzy spells? | <input type="checkbox"/> Periodontal treatment? |
| <input type="checkbox"/> Anemia? | <input type="checkbox"/> Gum abscesses? |
| <input type="checkbox"/> Sickle cell disease? | <input type="checkbox"/> Gums bleed when brushing? |
| <input type="checkbox"/> Cancer/Tumors? | <input type="checkbox"/> Mouth odor or bad taste? |
| <input type="checkbox"/> Kidney/bladder trouble? | <input type="checkbox"/> Bruise easily? |
| <input type="checkbox"/> Thyroid disease? | <input type="checkbox"/> Loose or shifting teeth? |
| <input type="checkbox"/> Radiation treatment? | <input type="checkbox"/> Trouble chewing/speaking? |
| <input type="checkbox"/> Chemotherapy? | <input type="checkbox"/> Fear of dental treatment? |
| <input type="checkbox"/> Tuberculosis? | <input type="checkbox"/> Sensitive teeth |
| <input type="checkbox"/> Drug/alcohol addiction? | <input type="checkbox"/> Cold sores or blisters? |

Have you had problems with dental anesthetic? __No __Yes

Have you had surgery in the past two years? __No __Yes

Please list any allergies that you have: _____

Have you ever been involved in a major accident? __No __Yes

When? _____

Nature of Injuries? _____

Did the symptoms start after this accident? No Yes

HAVE YOU HAD:

Recent X-rays? Date/Type? _____

MRI or CT Scan? Date? Explain _____

Date of last eye exam? _____

FOR WOMEN (optional):

Are you pregnant? No Yes

Expected due date? _____

Do you have a history of previous miscarriages? No Yes

Do you ovulate regularly? No Yes

Have you reached menopause? No Yes

Have you had a hysterectomy? No Yes

Have you been diagnosed as having PMS? No Yes

Do your nails break easily? No Yes

Does cold weather bother you? No Yes

PLEASE USE THE SPACE BELOW FOR ANY ADDITIONAL COMMENTS:

