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:

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

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.