HEALTH HISTORY

Date of last health care exam _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? ❑ No ❑ Yes

If yes, reason _____

Are you currently receiving care? ❑ No ❑ Yes If yes, nature of care _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

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

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please not that during you initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	❑ No	❑ Yes	Psychosis	❑ No	❑ Yes
Anemia	❑ No	❑ Yes	Sore/Enlarged Lymph Nodes	❑ No	❑ Yes
Diabetes	❑ No	❑ Yes	Previous Biopsies	❑ No	❑ Yes
Epilepsy	❑ No	❑ Yes	Slow- Healing Mouth Sores	❑ No	❑ Yes
Hepatitis, Any Form	❑ No	❑ Yes	Other Infections	❑ No	❑ Yes
Rheumatic Fever	❑ No	❑ Yes	Recurrent Illnesses	❑ No	❑ Yes
Asthma	❑ No	❑ Yes	Joint Replacement	❑ No	❑ Yes
HIV Positive or AIDS Related Complex	❑ No	❑ Yes	Glaucoma	❑ No	❑ Yes
Emphysema or other Respiratory Illnesses	❑ No	❑ Yes	Abnormal Bleeding from a cut	❑ No	❑ Yes
Abnormal Heart Condition	❑ No	❑ Yes	Liver Disease (including Jaundice)	❑ No	❑ Yes
Kidney	❑ No	❑ Yes	Unintentional Weight Loss/Gain	❑ No	❑ Yes
Heart (Surgery, Disease, Attack)	❑ No	❑ Yes	Latex Sensitivity	❑ No	❑ Yes
Venereal Disease	❑ No	❑ Yes	H.I.V. Infection/AIDS	❑ No	❑ Yes

One or more of the following symptoms may be indicative of Musculoskeletal Dysfunction of the head and neck. If you have any of the following symptoms, please indicate by circling the appropriate areas. (L = Left, R = Right)

Pain in the jaw joint	❑ L	❑ R	Pain in Tongue	❑ No	❑ Yes
Pain in ear	❑ L	❑ R	Loud Snoring	❑ No	❑ Yes
Pain around eyes	❑ L	❑ R	Mouth Breather at Night	❑ No	❑ Yes
Pain in lower jaw	❑ L	❑ R	Awaken with a Dry Mouth	❑ No	❑ Yes
Pain in upper jaw	❑ L	❑ R	Inability to Open Mouth	❑ No	❑ Yes
Pain in neck	❑ L	❑ R	Difficulty Swallowing	❑ No	❑ Yes
Pain in Shoulder	❑ L	❑ R	Constantly Tired	❑ No	❑ Yes
Pain in forehead	❑ L	❑ R	Dizziness (Vertigo)	❑ No	❑ Yes
Pain in temples	❑ L	❑ R	Difficulty Chewing	❑ No	❑ Yes
Pain in facial muscles	❑ L	❑ R	Facial muscle twitch	❑ L	❑ R
Clicking or popping sound in joint	❑ L	❑ R	Grating sound in joint	❑ L	❑ R
Ringing sound in ears	❑ L	❑ R	Fullness, pressure blockage in ears	❑ L	❑ R

Are you required to Pre- Medicate before dental treatment? ❑ No ❑ Yes

Women:	Are you Pregnant?	❑ No	❑ Yes
	If no, are you planning a pregnancy in the near future?	❑ No	❑ Yes
	Are you a nursing mother?	❑ No	❑ Yes
	Are you taking birth control pills?	❑ No	❑ Yes