MEDICAL HISTORY

Circle any of the following which the patient has OR has had:

Asthma/Allergies	Stroke	Tuberculosis	Chest Pain/Angina
Heart Pacemaker	Diabetes	Arthritis	Ulcers
Thyroid Disease	AIDS/HIV positive	Sinus Problems	Steroid Medication
Hepatitis	Bronchitis	Psychiatric Disorder	Rheumatic Fever
Anemia	Seizures/Epilepsy	Heart Murmur	Artificial Joint
Kidney Problems	High Blood Pressure	Bleeding Disorder	Mononucleosis
Syphilis/Gonorrhea	Emphysema	Anesthesia Problems	Heart Attack
Cancer			

Allergies?	Yes / No	What? ____________________
Mouth Breather?	Yes / No	
Speech Problems?	Yes / No	
Finger/Thumb Sucker?	Yes / No	Age? ____________________
Any Surgeries?	Yes / No	
Tonsil/Adenoid Removed?	Yes / No	What? ____________________
Pregnant?	Yes / No	
Any injuries to mouth?	Yes / No	Due Date? ____________________
Any Ear problems?	Yes / No	

Is the patient under the care of a physician for any reason OR taking any medication?

____

(Physician's Name) *(Medication)*

TMJ QUESTIONAIRE

Please complete the following questions ONLY if you have any form of jaw problems.

Has patient ever been treated for TMJ?	Yes / No
Has patient noticed limitations in opening the mouth?	Yes / No
Frequent Headaches?	Yes / No
Has the jaw ever been locked open/ closed or slipped out of place?	Yes / No
Any grinding/clenching of teeth?	Yes / No
Are tranquilizers, muscle relaxants, or anti-depressants being taken?	Yes / No
Does the pain interfere with normal day-to-day activities?	Yes / No

Signature: ____

EMERGENCY INFORMATION

Name of nearest relative not living with you ______________________________

Complete Address ______________________________

Phone ____________________ Relationship to Patient____________________

Signature (parent/guardian if minor____________________ Date ____________

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