

PATIENT MEDICAL/DENTAL HISTORY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

PLEASE MARK ANY ITEMS THE PATIENT HAS A HISTORY OF:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Lupus         | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Drug/alcohol abuse    | <input type="checkbox"/> TB            | <input type="checkbox"/> Arthritis         |
| <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Asthma        | <input type="checkbox"/> Smoking           |
| <input type="checkbox"/> Venereal disease      | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Smokeless tobacco |
| <input type="checkbox"/> Excessive bleeding    | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Fainting          |
| <input type="checkbox"/> Blood transfusion     | <input type="checkbox"/> Convulsions   | <input type="checkbox"/> Hypoglycemia      |
| <input type="checkbox"/> AIDS                  | <input type="checkbox"/> Heart murmur  | <input type="checkbox"/> Hepatitis         |
| <input type="checkbox"/> Psychotherapy         | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Hearing loss      |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Mononucleosis |  |

PLEASE MARK ALL THAT APPLY AND PROVIDE EXPLANATION:

- |  |  |
|--|--|
| <input type="checkbox"/> Allergies to drugs/ medications<br>_____<br>_____                   | <input type="checkbox"/> Frequent headaches<br>_____<br>_____  |
| <input type="checkbox"/> Surgery<br>_____<br>_____   | <input type="checkbox"/> Does jaw pop, click, or lock<br>_____<br>_____                                |
| <input type="checkbox"/> Under care of dentist, physician,<br>chiropractor<br>_____<br>_____ | <input type="checkbox"/> Pain in face, jaw, or back<br>_____<br>_____                                  |
| <input type="checkbox"/> Car accident<br>_____<br>_____                                      | <input type="checkbox"/> Grind or clench teeth<br>_____<br>_____                                       |
| <input type="checkbox"/> Head, neck, or face injury<br>_____<br>_____                        | <input type="checkbox"/> Medical problems requiring<br>premedication for dental work<br>_____<br>_____ |

LIST ANY AND ALL DRUGS YOU ARE TAKING:

(INCLUDE NAME AND REASON FOR USE)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the above information is correct

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Print \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Patient Name: \_\_\_\_\_ Male\_\_ Female\_\_ Date: \_\_\_\_\_

Age \_\_\_\_ Med Hx \_\_\_\_\_ Dent Hx \_\_\_\_\_ Injuries \_\_\_\_\_ Missing \_\_\_\_\_ 3<sup>rd</sup> Molars \_\_\_\_\_

Molar Classification \_\_\_\_\_ Cuspid Classification \_\_\_\_\_ Crowding \_\_\_\_\_ Spacing \_\_\_\_\_

Crossbite \_\_\_\_\_ Pathology \_\_\_\_\_ Overbite \_\_\_\_\_ Overjet \_\_\_\_\_ Facial Symmetry \_\_\_\_\_

Midline Dis \_\_\_\_\_ Func. Midline Dis \_\_\_\_\_ Profile \_\_\_\_\_ Hygiene \_\_\_\_\_

Cooperation \_\_\_\_\_ Extractions \_\_\_\_\_

Habits: Thumb Sucking      Mouth Breathing      Tongue Thrust      Finger Sucking

        Nail Biting              Lib Biting              Bruxism              Clenching

        Other: \_\_\_\_\_

TMJ chief complaint \_\_\_\_\_ Pain \_\_\_\_\_

Popping, clicking, grating subluxation \_\_\_\_\_ Headaches/Dizziness \_\_\_\_\_

Ear ringing, fullness, loss \_\_\_\_\_ Limitation on opening \_\_\_\_\_

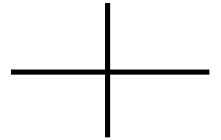
Sympton onset \_\_\_\_\_ Prior Tx or eval by specialist \_\_\_\_\_

Eyes blurring or pain \_\_\_\_\_ Hx of injury \_\_\_\_\_

Chief Complaint:

Other observations: \_\_\_\_\_

Arch Form \_\_\_\_\_



Treatment Recommendations:

Phase I: \_\_\_\_\_ Est Tx. Time \_\_\_\_\_ Fee \_\_\_\_\_  
          \_\_\_\_\_

Phase II: \_\_\_\_\_  
          \_\_\_\_\_

Retention: \_\_\_\_\_  
          \_\_\_\_\_