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: _____
(the sole purpose of providing your email is so we can confirm your appointment)
Driver's License _____
Social Security #: _____
Name of Spouse: _____
Emergency Contact:
Name:_____
Phone Number:_____
Relationship to Patient:_____
Parents' Name (if child): _____
If patient is a student: School_____ Year/Grade _____
Who may we thank for referring you to our practice:
_____

What are your specific complaints? List from most to least important.
1. _____
2. _____
3. _____

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? _____

		Facial pain (non-specific)	__L __R
Top of Head	__L __R	Clicking/popping in joint	__L __R
Forehead	__L __R	Temples	__L __R
Back of Head (occipital)	__L __R	Behind Eyes	__L __R
Pain in neck	__L __R	Pain in shoulder	__L __R
Pain in ear	__L __R	Dizziness (Vertigo)	_____
Ear congestion	__L __R	Pain in jaw joint	__L __R
Tinnitus (Ringing in Ear)	__L __R	Grating sound in joint	__L __R
Facial muscle twitch	__No __Yes	Difficulty swallowing	__No __Yes
Difficulty breathing through nose	__No __Yes	Difficulty chewing	__No __Yes

Partial inability to open mouth ___No ___Yes ___ Constant ___Specific

Loose teeth (specify) _____

OCCLUSAL HABITS (check those which apply):

__ Clenching __AM __PM	__ Grinding on Teeth __AM __PM
__ Teeth hit in front first	__ Cheek Biting
__ Gum Chewing	__ Pipe Smoking
__ Pencil Biting	__ Nail Biting

__OTHER:_____

POSTURAL HABITS (check those which apply):

__ Phone cradling	__ Leans chin on hand
__ TV Watching	__ Heavy Lifting

__ 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: _____
_____

_____Do you smoke?
_____History of diabetes in your family?
_____Do you take blood thinners or aspirin?
_____Heart trouble?
_____Artificial joints or implants?
_____High blood pressure?
_____Low blood pressure?
_____Arthritis rheumatism?
_____Persistent cough?
_____Epilepsy or seizures?
_____Heart murmur?
_____Rheumatic fever?
_____Congenital heart lesions?
_____Artificial heart valve?
_____Heart surgery?
_____Hemophilia?
_____Shortness of breath?
_____Allergies or hives?
_____Fainting or dizzy spells?
_____Anemia?
_____Sickle cell disease?
_____Cancer/Tumors?
_____Kidney/bladder trouble?
_____Thyroid disease?
_____Radiation treatment?
_____Chemotherapy?
_____Tuberculosis?
_____Drug/alcohol addiction?
_____Frequent thirst/urination?
_____A nervous person?
_____Blood transfusion?
_____AIDS?
_____HIV?
_____Contact lenses?
_____Psychiatric care?
_____Hepatitis?
_____Liver disease?
_____Jaundice?
_____Diabetes?
_____Ulcers?
_____Asthma?
_____Hay fever?
_____Sinus trouble?
_____Scarlet fever?
_____Orthodontic treatment?
_____Lightened your teeth before?
_____Periodontal treatment?
_____Gum abscesses?
_____Gums bleed when brushing?
_____Mouth odor or bad taste?
_____Bruise easily?

_____Loose or shifting teeth? _____Sensitive teeth
_____Trouble chewing/speaking? _____Cold sores or blisters?
_____Fear of dental treatment?

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:
_____
_____
_____
_____