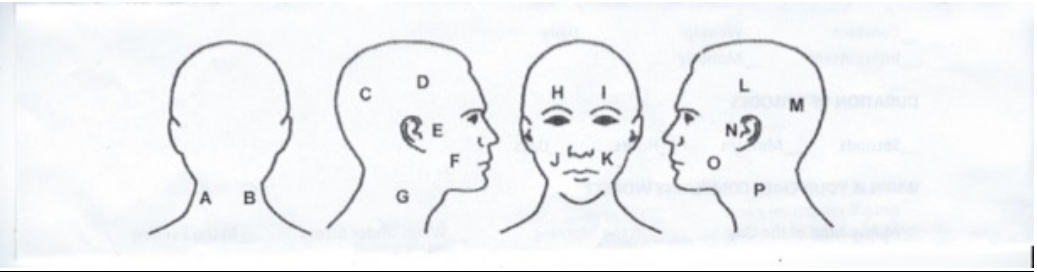
# CONFIDENTIAL MEDICAL HISTORY

**WHAT IS THE MAIN REASON YOU ARE HERE?** (Please indicate all applicable with check marks)

| | | | | |
|---|---|---|---|---|
| **Tongue Pain** | **Burning Mouth** | **Eye Pain** | **Jaw Locked Closed** | **Painful Jaw Clicking** |
| **Tooth Pain** | **Clenching** | **Facial Pain** | **Muscle Pain** | **Painless Jaw Clicking** |
| **Lip Pain** | **Bruxism** | **Forehead Pain** | **Neck Pain** | **Ringing In Ears** |
| **Temple Pain** | **Dizziness** | **Grating Jaw Noises** | **Numbness** | **Sinus Pain** |
| **Teeth Don't Fit** | **Earaches** | **Jaw Locks Open** | **Oral Ulcers/Sores** | **Spontaneous TMJ Pain** |
| **Headaches** | **Heavy Snoring** | **Jaw Pain** | **TMJ Pain On Opening** | **TMJ Pain On Closing** |
| **Migraines** | **Radiology Consult** | **TMJ Pain When chewing** | **Jaw Won't Open wide** | **Other:** |

**PLEASE INDICATE WITH AN "X" ON THE PRIMARY LOCATION(S) OF YOUR PAIN**
(If Applicable)




**DESCRIBE YOUR PAIN** (Please indicate all applicable with check marks)

| | | | |
|---|---|---|---|
| **Aching** | **Crushing** | **Electric Like** | **Radiating** |
| **Annoying** | **Deep** | **Gradual Onset** | **Sharp** |
| **Bilateral (Both Sides)** | **Diffuse** | **Localized** | **Steady** |
| **Burning** | **Dull** | **Pressure** | **Sudden Onset** |
| **Superficial** | **Tightness** | **Throbbing** | **Other:** |

# CONFIDENTIAL MEDICAL HISTORY

**WHAT BROUGHT ON THESE COMPLAINTS?** (Please indicate all applicable with check marks)

| | | |
|---|---|---|
| Following a Dental Procedure | Following Trauma to the Neck | Unknown Origin |
| Following a Motor Vehicle Accident -Date: | Spontaneously | While Drinking (Hot/Cold) |
| Following a Surgical Procedure | Following a Stressful Episode | Other: |
| Following Trauma to the Head | While eating | Additional Comments: |

**HOW LONG HAVE YOU HAD THESE COMPLAINTS?** (Please indicate with check marks)

As long as I can remember __.

Days __. Months __ . Years __. Since the age of __.

**DESCRIBE THE FREQUENCY OF YOUR PAIN**

Constant __. Weekly __. Daily __.
Intermittent __. Monthly __.

**DURATION OF EPISODES**

Seconds __ .Hours __.
Minutes __. Days __.

**WHEN IS YOUR CHIEF COMPLAINT AT ITS WORST?** (Please indicate with check marks)

| | | | |
|---|---|---|---|
| At any time of the day | In the Morning | When Under Stress | During Menstrual Cycle |
| After Eating | Upon Wakening | Mid- Day | Other: |
| In the Evening | Variably | After Drinking | Additional Comments: |

**WHAT OTHER PRACTIONERS HAVE YOU SEEN FOR YOUR CHIEF COMPLAINT?**

# CONFIDENTIAL MEDICAL HISTORY

(Please indicate all applicable with check marks)

No Other Practitioners __
Acupuncturist __
Allergist __
Anesthesiologist __
Chiropractor __
Dermatologist __
Endocrinologist __
Endodontist __
General Dentist __
Internist __
Neurologist __
Neurosurgeon __
Optometrist __
Ophthalmologist __
Oral Surgeon __
Orthodontist __
ENT __
Gynecologist __
Surgeon __
Rheumatologist __
Psychologist __
Psychiatrist __
Physical Therapist __
Family Physician __

**DO YOU USE TOBACCO?**

Do Not Smoke ___.

| | | |
|---|---|---|
| Smoke Cigarettes | Times per Day: | How Many Years: |
| Smoke Cigars | Times per Day: | How Many Years: |
| Smokeless Tobacco | Times per Day: | How Many Years: |
| Smokes a Pipe | Times per Day: | How Many Years: |

**CAFFEINE HISTORY**

| | | |
|---|---|---|
| No Caffeinated Beverages | Cups of Caffeination Coffee Daily: | Ounces of Caffeinated Soda Daily: |

**HOW OFTEN DO YOU CONSUME ALCOHOL?**

| | | | |
|---|---|---|---|
| No Alcoholic Beverages | Less than one Ounce Daily | 1-3 Ounces daily | More than 3 Ounces Daily |

**ALLERGIES** (Please indicate with check marks)

NO KNOWN ALLERGIES ____
Codeine __
Bug Bites __
Dust and Pollen __
Food Allergies __
General Anesthesia __
Hay Fever __
Medication Allergies __
Penicillin ___
Sulfa Drugs __
Other _____

**DESCRIBE PREVIOUS DENTAL TREATMENTS** (Please indicate with check marks)

Bite Adjustment __
Bite Splint __
Crowns or Bridges __
Fractured Jaw __
Gum Surgery __
Oral (Not TMJ) Surgery
Orthodontics __
Removable Dentures __
Root Canals __
Routine Dental Care __
Teeth Extracted and Not Replaced _

# CONFIDENTIAL MEDICAL HISTORY

TMJ Surgery __ Wisdom Teeth Extracted __
Other _____

**WHAT WAS THE SUCCESS OF THIS TREATMENT?**
Complete __ Minimal __ Significant __ None

**HEALTH HISTORY -** Mark **ALL** responses you have had or currently have:

No Related Medical Problems __

| | | |
|---|---|---|
| Aids __ | Emphysema __ | Leukemia __ |
| ARC __ | Fractures(s) __ | Liver Disease __ |
| Anemia __ | Fainting/Dizziness __ | Mononucleosis __ |
| Anxiety __ | Heart Disease __ | Nervous Breakdown __ |
| Arthritis __ | Heart Murmur __ | Neuralgia __ |
| Asthma __ | Hemophilia __ | Neurosis __ |
| Bronchitis __ | Hepatitis __ | Parkinson's Disease __ |
| Cancer __ | History of Prior Surgery __ | Pregnancy __ |
| Chemotherapy __ | Hormonal Disturbance __ | Radiation Treatment __ |
| Depression __ | Hypertension __ | Reproductive Tract Disorder __ |
| Dermatitis __ | Hypotension __ | Seizures __ |
| Diabetes __ | Kidney Disease __ | Stomach Ulcers __ |
| Urinary Tract Problems __ | | Yeast (Fungus)__ |
| Weight Gain/Loss __ | | Other ___ |

Psychologic Counseling Related to Chief Complaint __
Psychologic Counselling Not Related to Chief Complaint __

**PLEASE MARK THE APPROPRIATE RESPONSES** (Please indicate with check marks)

| | |
|---|---|
| I feel depressed __ | I have difficulty sleeping __ |
| I feel anxious __ | I have thought about suicide __ |

**Please list medications you are <u>currently</u> using for your chief complaint**

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**Please list medications that were past <u>effective</u> for your chief complaint**

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**Please list medications that were past <u>ineffective</u> for your chief complaint**

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## Financial Agreement

Date:

I, _____ authorize ORTHO PLACE to charge my credit card below for agreed upon costs. I understand that my information will be saved on file for future transactions on my account.

Please complete all fields. You may cancel this authorization at any time by contacting Ortho Place. This authorization will remain in effect until cancelled.

| CREDIT CARD INFORMATION |
| --- |
| CARD TYPE: ____ Mastercard ____ Visa ____ American Express<br>____ Other: _____ |
| Cardholder Name (as shown on card): _____ |
| Card Number: _____ |
| Expiration Date (mm/yy): _____ |

*For alternative payment methods, please see front desk*