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MEDICAL HISTORY Cont.

Please check all that apply and leave all others blank, if there is anything not listed please indicate the information in the OTHER section.

Kidney/Bladder History
- □ Prostate Disorders
- □ Renal Failure
- □ Stress Incontinence
- □ Urinary, Bladder Infections
- □ Kidney Stones
- □ Urinary Calculus

Endocrine History
- □ Diabetes Mellitus
- □ Thyroid Disorders
- □ Chronic Fatigue

Neurological History
- □ Epilepsy
- □ TIA
- □ Stroke Syndrome
- □ Multiple Sclerosis
- □ Depression
- □ Bipolar Disorder
- □ ADHD
- □ Migraine Headaches
- □ Vascular Headaches

Musculoskeletal History
- □ Osteoarthritis
- □ Arthritis
- □ Rheumatoid Arthritis
- □ Osteoporosis
- □ Fibromyalgia

OTHER HISTORY ITEMS NOT LISTED: _____

CURRENT SYMPTOMS

Systemic symptoms
- □ Feeling tired or poorly
- □ Weight change
- □ Chills
- □ Fever

Otolaryngial Symptoms
- □ Mouth sores
- □ Difficulty swallowing (dysphagia)
- □ Difficulty chewing
- □ Dentures currently being worn
- □ Dentures improperly fitting

Head symptoms
- □ Headache
- □ Facial pain
- □ Sinus pain
- □ Tooth pain

Musculoskeletal symptom
- □ Joint pain, localized in the jaw (joint)
- □ Diffuse joint pains (arthralgias)
- □ Joint pain, localized
- □ Joint swelling, localized
- □ Muscle aches
- □ Muscle cramps
- □ Legs feel restless
- □ Other

Neck symptoms
- □ Neck pain
- □ Neck stiffness
- □ Lump or swelling

Gastrointestinal
- □ Appetite
- □ Heartburn
- □ Nausea
- □ Vomiting
- □ Abdominal pain
- □ Regurgitation
- □ Yellow skin/eyes (jaundice)
- □ Inability to pass gas
- □ Bowel movement frequency
- □ Diarrhea
- □ Unable to control passing gas
- □ Constipation
- □ Rectal Pain

Neurological symptoms
- □ Dizziness
- □ Vertigo
- □ Fainting (syncope)
- □ Motor disturbances
- □ Sensory disturbances
- □ Decreased concentrating ability

Cardiovascular
- □ Chest pain or discomfort
- □ Palpitations
- □ Slow heart rate
- □ Leg pain with exercise
- □ Cold hands/feet

Endocrine
- □ Temperature intolerance
- □ Excessive sweating
- □ Hot flashes
- □ Muscle weakness
- □ Muscle weakness
- □ Sexual complaints
- □ Changes in body proportion
- □ Hair symptoms

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CURRENT SYMPTOMS Cont. Please check all that apply and leave all others blank

Psychological symptoms
- ☐ Mood
- ☐ Energy level
- ☐ Behavior
- ☐ Sleep disturbances
- ☐ Neurological symptoms

Skin symptoms
- ☐ Pruritus
- ☐ Skin Lesions
- ☐ Rashes

OTHER SYMPTOMS NOT LISTED: _____

HEAD PAIN

If you have different levels of headaches, the below refers to the worst headache as opposed to a daily tension-type headache.
Location L=Left R=Right B=Both

☐L ☐R ☐B Frontal (Forehead) ☐Recent ☐Chronic (over 5 months)
Severity ☐Mild ☐Moderate ☐Severe
Duration ☐Min. ☐Hrs. ☐Days
Frequency ☐Occasional ☐Frequent ☐Constant

☐L ☐R ☐B Generalized ☐Recent ☐Chronic (over 5 months)
Severity ☐Mild ☐Moderate ☐Severe
Duration ☐Min. ☐Hrs. ☐Days
Frequency ☐Occasional ☐Frequent ☐Constant

☐L ☐R ☐B Parietal (Top of head) ☐Recent ☐Chronic (over 5 months)
Severity ☐Mild ☐Moderate ☐Severe
Duration ☐Min. ☐Hrs. ☐Days
Frequency ☐Occasional ☐Frequent ☐Constant

☐L ☐R ☐B Occipital (Back of Head) ☐Recent ☐Chronic (over 5 months)
Severity ☐Mild ☐Moderate ☐Severe
Duration ☐Min. ☐Hrs. ☐Days
Frequency ☐Occasional ☐Frequent ☐Constant

☐L ☐R ☐B Temporal (Temple Area) ☐Recent ☐Chronic (over 5 months)
Severity ☐Mild ☐Moderate ☐Severe
Duration ☐Min. ☐Hrs. ☐Days
Frequency ☐Occasional ☐Frequent ☐Constant

Please check the appropriate boxes, if applicable.

JAW PAIN
L☐ R☐ Jaw Pain when opening
L☐ R☐ Jaw Pain when chewing
L☐ R☐Jaw Pain at rest

JAW JOINT SOUNDS (Clicking, Crunching, Popping)
L☐ R☐ Jaw Sounds when opening
L☐ R☐ Jaw Sounds when chewing
L☐ R☐ Jaw Sounds at rest

JAW LOCKING
Yes☐ No☐ Jaw Locks Closed
Yes☐ No☐ Jaw Locks Open

JAW JOINT SYMPTOMS
Yes☐ No☐ Teeth Clenching Day☐ Night☐
Yes☐ No☐ Teeth Grinding Day☐ Night☐

EYE RELATED CONDITIONS
Yes☐ No☐ Blurred Vision
Yes☐ No☐ Double Vision
Yes☐ No☐ Eye Pain

Yes☐ No☐ Pain or pressure behind the eyes
Yes☐ No☐ Extreme Sensitivity to light
Yes☐ No☐ Wear Glasses or Contacts

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EAR RELATED CONDITIONS

L☐ R☐ Buzzing in the ears
L☐ R☐ Ear congestion
L☐ R☐ Ear pain
L☐ R☐ Hearing Loss
L☐ R☐ Itching or stuffiness in the ears
L☐ R☐ Pain behind the ear
L☐ R☐ Pain in front of the ear
L☐ R☐ Recurrent ear infections
L☐ R☐ Ringing in the ear (Tinnitus)

MOUTH AND NOSE RELATED CONDITIONS

Yes☐ No☐ Dry Mouth
Yes☐ No☐ Chronic sinusitis
Yes☐ No☐ Frequent snoring
Yes☐ No☐ Burning tongue
Yes☐ No☐ Broken teeth
Yes☐ No☐ Frequent biting of the cheek

SLEEP CONDITIONS

Please select yes or no answers on your average sleep experience and/or what a sleep partner has told you

Sleep Positions Side☐ Back☐ Stomach☐ Varies☐
Is it easy to fall asleep? Yes☐ No☐
Do you feel rested upon AM waking? Yes☐ No☐
Stopped breathing during sleep? Yes☐ No☐
Average hours of sleep per night _____
Do you wake often during the night? Yes☐ No☐
Gasping or Choking during sleep? Yes☐ No☐
Have you ever had a Sleep Study (PSG)? Yes☐ No☐
Result was:_____

Family History

☐ Diabetes Mellitus
☐ Cancer
☐ Loss of Hearing
☐ Allergies
☐ Stroke
☐ Hypertension
☐ Asthma
☐ Heart Disease
☐ CAD – Coronary artery disease
☐ CHF – congestive heart failure
☐ Pulmonary Hypertension
☐ PVD – peripheral vascular disease
☐ Migraine Headache
☐ Cluster Headache
☐ Meniere's Disease
☐ Neurofibromatosis Type 1 (Recklinghausen's Disease)

Social History

☐ Life circumstance event
☐ Caffeine use
☐ Tobacco use
☐ Smoking cigarettes
☐ Alcohol
☐ Drug use
☐ Marijuana use
☐ Occupation _____

By signing below, I authorize the release of all examination findings and diagnosis, report and treatment plans, etc. to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all chargers incurred for my treatment regardless of insurance coverage.

Patient/Guardian Signature _____ **Date:** _____

Printed Patient Name_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?

Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (ex. a theater or a meeting)	☐	☐	☐	☐
As a passenger in a car For an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to Someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Total Score: _____

Patient name: _____ Date: _____

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HEALTH CARE PRACTITIONERS AND PATIENT COMMUNICATION

Please provide us with the names and addresses of all of your doctors and health care providers.

FAMILY DENTIST

PROVIDER NAME: _____

CITY/STATE:_____

□ORTHODONTIST □ORAL SURGEON □ENDODONTIST

PROVIDER NAME: _____

CITY/STATE:_____

FAMILY PHYSICIAN

PROVIDER NAME: _____

CITY/STATE:_____

SPECIALTY PROVIDERS

SPECIALTY: _____

PROVIDER NAME: _____

CITY/STATE:_____

SPECIALTY: _____

PROVIDER NAME: _____

CITY/STATE:_____

SPECIALTY: _____

PROVIDER NAME: _____

CITY/STATE:_____

By signing below, I am giving my permission to communicate with the above named health care providers regarding my treatment.

Patient/Guardian Signature _____ **Date:** _____

Printed Patient Name_____

Print