



TMJ MEDICAL HISTORY

Patient Name: _____ Date: _____

Date of last complete Medical Examination? Month: _____ Year: _____

Weight: _____ Height: _____

Please list any medications that you are currently taking:

Medication(s)	Quantity	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you under a physician's care now? Yes No

Explain: _____

Treating Physician: _____

Do you have, or have you had, any of the following?

Heart Surgery <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No	Latex Sensitivities <input type="radio"/> Yes <input type="radio"/> No	Trouble Breathing when Sleeping <input type="radio"/> Yes <input type="radio"/> No
Heart Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No	Sleep with Bed Elevated <input type="radio"/> Yes <input type="radio"/> No
Heart Attack <input type="radio"/> Yes <input type="radio"/> No	How is it controlled? _____	Tonsil or Adenoid Problems <input type="radio"/> Yes <input type="radio"/> No	Frequently do not eat breakfast <input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Thyroid Problems <input type="radio"/> Yes <input type="radio"/> No	Tonsil or Adenoid Surgery <input type="radio"/> Yes <input type="radio"/> No	More than one alcoholic drink per day <input type="radio"/> Yes <input type="radio"/> No
How is it controlled? _____	Kidney Trouble <input type="radio"/> Yes <input type="radio"/> No	Tumor or Cancer <input type="radio"/> Yes <input type="radio"/> No	How many? _____
Chest Pain <input type="radio"/> Yes <input type="radio"/> No	Hepatitis <input type="radio"/> Yes <input type="radio"/> No	How was it treated? _____	Smoke or Use Tobacco <input type="radio"/> Yes <input type="radio"/> No
Shortness of Breath <input type="radio"/> Yes <input type="radio"/> No	When? _____	Major Operation <input type="radio"/> Yes <input type="radio"/> No	Radiation Therapy <input type="radio"/> Yes <input type="radio"/> No
Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	What for? _____	Chemotherapy <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No	Significant Weight Change in the Last Year <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Loss _____ lbs. Gain _____ lbs.	AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No
Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No	Contact Lenses <input type="radio"/> Yes <input type="radio"/> No	Diet Medically Supervised <input type="radio"/> Yes <input type="radio"/> No	Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No
When? _____	Artificial Joints or Hip <input type="radio"/> Yes <input type="radio"/> No	For what purpose? _____	Hemophilia <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Rheumatism <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	Vitamin/Mineral Supplements <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No	Fatigue easily <input type="radio"/> Yes <input type="radio"/> No	Bruise Easily <input type="radio"/> Yes <input type="radio"/> No
Ankle Swelling <input type="radio"/> Yes <input type="radio"/> No	Drug/Medication Allergies <input type="radio"/> Yes <input type="radio"/> No	Sleep Well <input type="radio"/> Yes <input type="radio"/> No	Nervous Disorders <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	What? _____	Snore <input type="radio"/> Yes <input type="radio"/> No	Neurological Disorder <input type="radio"/> Yes <input type="radio"/> No
Fainting/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Asthma/Hay Fever/Allergies <input type="radio"/> Yes <input type="radio"/> No		Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No
Stroke <input type="radio"/> Yes <input type="radio"/> No			Nervous or Anxious <input type="radio"/> Yes <input type="radio"/> No
When? _____			Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No

Do you sleep with more than two pillows? Yes No

