OAK PARK DENTAL

Enhancing your life, health and smile.

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 ❍ Yes ❍ No
Heart Disease ❍ Yes ❍ No
Heart Attack ❍ Yes ❍ No

High Blood Pressure ❍ Yes ❍ No
How is it controlled? _____

Chest Pain ❍ Yes ❍ No
Shortness of Breath ❍ Yes ❍ No
Mitral Valve Prolapse ❍ Yes ❍ No
Artificial Heart Valve ❍ Yes ❍ No
Pacemaker ❍ Yes ❍ No

Rheumatic Fever ❍ Yes ❍ No
When? _____

Arthritis/Rheumatism ❍ Yes ❍ No
Cortisone Medicine ❍ Yes ❍ No
Ankle Swelling ❍ Yes ❍ No
Anemia ❍ Yes ❍ No
Fainting/Dizziness ❍ Yes ❍ No

Stroke ❍ Yes ❍ No
When? _____

Ulcers ❍ Yes ❍ No

Diabetes ❍ Yes ❍ No
How is it controlled? _____

Thyroid Problems ❍ Yes ❍ No
Kidney Trouble ❍ Yes ❍ No

Hepatitis ❍ Yes ❍ No
When? _____

Liver Disease ❍ Yes ❍ No
Yellow Jaundice ❍ Yes ❍ No
Glaucoma ❍ Yes ❍ No
Contact Lenses ❍ Yes ❍ No
Artificial Joints or Hip ❍ Yes ❍ No
Emphysema ❍ Yes ❍ No
Tuberculosis ❍ Yes ❍ No

Drug/Medication Allergies ❍ Yes ❍ No
What? _____

Asthma/Hay Fever/Allergies ❍ Yes ❍ No

Latex Sensitivities ❍ Yes ❍ No
Sinus Trouble ❍ Yes ❍ No
Tonsil or Adenoid Problems ❍ Yes ❍ No
Tonsil or Adenoid Surgery ❍ Yes ❍ No

Tumor or Cancer ❍ Yes ❍ No
How was it treated? _____

Major Operation ❍ Yes ❍ No
What for? _____

Significant Weight Change in the Last Year ❍ Yes ❍ No
Loss _____ lbs. Gain _____ lbs.

Diet Medically Supervised ❍ Yes ❍ No
For what purpose? _____

Vitamin/Mineral Supplements ❍ Yes ❍ No
Fatigue easily ❍ Yes ❍ No
Sleep Well ❍ Yes ❍ No
Snore ❍ Yes ❍ No

Trouble Breathing when Sleeping ❍ Yes ❍ No

Sleep with Bed Elevated ❍ Yes ❍ No

Frequently do not eat breakfast ❍ Yes ❍ No

More than one alcoholic drink per day ❍ Yes ❍ No
How many? _____

Smoke or Use Tobacco ❍ Yes ❍ No
Radiation Therapy ❍ Yes ❍ No
Chemotherapy ❍ Yes ❍ No
Venereal Disease ❍ Yes ❍ No
AIDS/HIV Positive ❍ Yes ❍ No
Blood Transfusion ❍ Yes ❍ No
Hemophilia ❍ Yes ❍ No
Sickle Cell Disease ❍ Yes ❍ No
Bruise Easily ❍ Yes ❍ No
Nervous Disorders ❍ Yes ❍ No
Neurological Disorder ❍ Yes ❍ No
Epilepsy or Seizures ❍ Yes ❍ No
Nervous or Anxious ❍ Yes ❍ No
Psychiatric Care ❍ Yes ❍ No

Do you sleep with more than two pillows? ❍ Yes ❍ No

TMJ MEDICAL HISTORY

FOR WOMEN ONLY (Optional)

Are you pregnant or trying to get pregnant? ❍ Yes ❍ No

Expected delivery date: _____

Do you have a history of previous miscarriages? ❍ Yes ❍ No

Do you ovulate regularly? ❍ Yes ❍ No

Have you reached menopause? ❍ Yes ❍ No

List supportive medications taken: _____

Have you had a hysterectomy? ❍ Yes ❍ No

Have you been diagnosed as having PMS? ❍ Yes ❍ No

Do your nails break easily? ❍ Yes ❍ No

Does cold weather bother you? ❍ Yes ❍ No

Please write in any other pertinent information that has not been covered previously:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

AUTHORIZATION

I hereby authorize the Doctor and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these medical and dental histories is correct to the best of my knowledge. I also authorize the doctor and/or staff to contact my healthcare giver(s) concerning my treatment if necessary.

_____ _____

Patient/Guardian Signature Date