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Patient Name: \_\_\_\_\_ Male/Female \_\_\_\_\_ Age: \_\_\_\_\_

• **Patients History** (please check if applicable)

AIDS/HIV	_____	Hemophilia	_____
Hepatitis	_____	Herpes	_____
Anemia	_____	High Blood Pressure	_____
Artificial Heart Valves	_____	Jaw Pain	_____
Asthma	_____	Mitral Valve Prolapse	_____
Back Problems	_____	Nervous Problems	_____
Bite Nails	_____	Pacemaker Heart	_____
Bleeding Abnormally	_____	Psychiatric Care	_____
Cancer	_____	Respiratory Disease	_____
Cardiac Problems	_____	Rheumatic/Scarlet Fever	_____
Chemical Dependency	_____	Shingles	_____
Chew on Pens/Pencils	_____	Sinus Problems	_____
Circulatory Problems	_____	Speech Problems	_____
Cough (persistent)	_____	Spina Bifida	_____
Chronic Strep Throat	_____	Stroke	_____
Diabetes	_____	Surgical Implant	_____
Emphysema	_____	Skin Rash	_____
Epilepsy	_____	Thyroid Disease	_____
Fainting	_____	Tobacco Habit	_____
Food Allergies	_____	Tonsilitis	_____
Glaucoma	_____	Tuberculosis	_____
Headaches	_____	Ulcer/Colitis	_____
Heart Murmur	_____	Heart Poblems	_____

Puberty: Girls – Has she begun menstration? Yes/No      Boys – Has voice changed? Yes/No

Please list any serious Illnesses, Physical or Mental: \_\_\_\_\_

Current Medications: \_\_\_\_\_

• **Allergies** (please circle if applicable)      Latex      Drug      Food

Please provide specific details if any allergies: \_\_\_\_\_

Patient Height: \_\_\_\_\_ Patient Weight: \_\_\_\_\_ Mother's Height: \_\_\_\_\_ Father's Height: \_\_\_\_\_

Family or Relatives treated in our Office: \_\_\_\_\_

Have you consulted an orthodontist previously? Yes/No      Is this a second opinion? Yes/No

In your own words what is the problem: \_\_\_\_\_

• **TMJ/TMD**

Do you have pain and limitation of jaw movements? Yes/No      How long? \_\_\_\_\_

Where is the pain located? \_\_\_\_\_

Does it come and go throughout the day or is it fairly constant? \_\_\_\_\_

How long does each episode last? \_\_\_\_\_

Is the pain a dull throb or a shooting pain? \_\_\_\_\_

Does gentle pressure feel comfortable? \_\_\_\_\_

Is there soreness to the touch? \_\_\_\_\_

How long have joint sounds been present? \_\_\_\_\_

Do joint sounds include a click or pop when opening or closing? \_\_\_\_\_

Are crunchy or gravelly sounds present? \_\_\_\_\_

Are sounds present with slight jaw movements or only during chewing hard foods and wide opening? \_\_\_\_\_

Is it difficult to open the mouth at times or move the jaw from one side to the other? \_\_\_\_\_

Is there pain on side-to-side or wide opening movement? \_\_\_\_\_

Does the lower jaw ever lock open, requiring assistance in closure? \_\_\_\_\_

Is bumping or jerking of the jaw present during opening or closing? \_\_\_\_\_

Does the jaw open straight down or regularly shift to one side? \_\_\_\_\_

Is headache, ringing in the ears, or dizziness present? \_\_\_\_\_

Does the bite feel uneven? \_\_\_\_\_

Are fillings broken or teeth worn excessively? \_\_\_\_\_

Is clenching or grinding behavior common? \_\_\_\_\_

What is the present level of stress or emotional tension? \_\_\_\_\_