HEALTH HISTORY

Dennis K. Barker, D.D.S.

Name: ______________________________ Date: ______________

Address: ______________________________

Date of Birth: ______________________________ Home Phone: ______________

Name of Employer: ______________________________ Work Phone: ______________

Social Security Number: ______________________________ Driver's License #: ______________

Responsible Party: Name & Address: ______________________________

Referred by: ______________________________

Physician Name: ______________________________ Phone #: ______________

Address: ______________________________ City: ______________ State: ________ Zip: ________

Have you been under the care of a medical doctor during the past two years?..Yes No

If yes, for what? ______________________________

Have you taken any medication or drugs during the past two years?..Yes No

Are you taking any medication, drugs or pills now?..Yes No

If yes, please list name and dosage ______________________________

Are you aware of having any allergic (or adverse reaction) to any medication or substance?...Yes No

If yes, please list: ______________________________

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Condition			Condition			Condition		
Heart (Surgery, Disease, Attack)….	Yes	No	Ulcers………………….	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain…………………………..	Yes	No	Diabetes………………	Yes	No	Venereal Disease…………………	Yes	No
Congenital Heart Disease………….	Yes	No	Thyroid Problems……	Yes	No	A.I.D.S.……………………………	Yes	No
Heart Murmur………………………..	Yes	No	Glaucoma……………	Yes	No	H.I.V. Positive……………………	Yes	No
High Blood Pressure………….……	Yes	No	Contact Lenses………	Yes	No	Cold Sores / Fever Blisters………	Yes	No
Mitral Valve Prolapse………………	Yes	No	Emphysema…………..	Yes	No	Blood Transfusions………………	Yes	No
Artificial Heart Valve………………..	Yes	No	Chronic Cough……….	Yes	No	Hemophilia………………………	Yes	No
Heart Pacemaker…………………..…	Yes	No	Tuberculosis…………..	Yes	No	Sickle Cell Anemia……………….	Yes	No
Rheumatic Fever……………………	Yes	No	Asthma………………..	Yes	No	Bruise Easily……………………	Yes	No
Arthritis / Rheumatism……………...	Yes	No	Hay Fever……………..	Yes	No	Liver Disease……………………..	Yes	No
Cortisone Medicine…………………	Yes	No	Latex Sensitivity………	Yes	No	Yellow Jaundice…………………..	Yes	No
Swollen Ankles……………………..…	Yes	No	Allergies or Hives…….	Yes	No	Neurological Disorders……………	Yes	No
Stroke………………………………..	Yes	No	Sinus Trouble…………	Yes	No	Epilepsy or Seizures……………..	Yes	No
Diet (Special / Restricted)………….	Yes	No	Radiation Therapy……	Yes	No	Fainting or Dizzy Spells…………..	Yes	No
Artificial Joints (hip,knee,etc.)……..	Yes	No	Chemotherapy………..	Yes	No	Nervous / Anxious………………..	Yes	No
Kidney Trouble………………………	Yes	No	Tumors………………..	Yes	No	Psychiatric / Psychological Care...	Yes	No

Have you lost or gained more than 10 pounds in the past year?..Yes No

Do you have or have you had any disease, condition, or problem not listed? ....Yes No

If yes, please list: ______________________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature ______________________________ Date: ______________

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QUESTIONNAIRE FOR TMJ PROBLEMS

Date: ____________________

Name: ____________________ Age: ________ Phone: ____________

Address: ____________________ City: ____________ State: ________ Zip: ________

Referred by: ____

Do you have headaches? ________ Neck Pain ________ Jaw Pain ________ Ear ________

Face ________ Eye ________ Other ____________________

Which side hurts? Right ______ Left ______ Both ______

How long have you had these symptoms? Years ______ Months ______ Days ______

Is the pain constant? ________ Aching ________ Stabbing ________ Burning ________

Is the pain worse in the afternoon? ____________ Or in the morning? ____________

Does it hurt to chew? ____________ Open Wide? ____________

Does your jaw make a popping noise? ________ Clicking ________ Grinding ________

Has your jaw ever locked or slipped out of place? ____________________

Do you ever clench or grind your teeth? ________ Day ________ Night ________

Do you have problems with your ears? ________ Hearing ________ Dizziness ________

Is it difficult to swallow? ________ Painful ________

Are your teeth sore or sensitive? ________

Are you taking medicine of any kind? ______________________________

____

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS:

	Yes	No	
14.	________	________	Do you wear, or have you ever worn, a splint, bite plate or appliance?
15.	________	________	Have you ever been treated for a “bad bite”?
16.	________	________	Have you ever had orthodontic treatment?
17.	________	________	Do you have extensive dental crowns and bridges?
18.	________	________	Are you missing any back teeth?
19.	________	________	Do you wear a removable partial denture?
20.	________	________	Have you ever been treated for problems with your jaw joint or for facial muscle spasms?
21.	________	________	Do you ever awaken with an awareness of your teeth or jaws?
22.	________	________	Have you ever been told that you grind your teeth in your sleep?
23.	________	________	Do your teeth hurt from biting?
24.	________	________	Do you have any pain or soreness around your eyes, ears or other parts or your body?
25.	________	________	Do you have difficulty hearing?
26.	________	________	Do you ever have “tension” headaches?
27.	________	________	Do you ever have migraine headaches?
28.	________	________	Do you frequently have stiff neck muscles or neck aches?
29.	________	________	Do your jaw muscles become tired frequently?
30.	________	________	Do you have difficulty opening your mouth wide?
31.	________	________	Have you ever had arthritis?
32.	________	________	Does any family member or relative have arthritis or gout?
33.	________	________	Have you ever received a severe blow to the side of your head or jaw?

	Yes	No	
34.	________	_______	Have you ever had pain in your jaw joint?
35.	________	_______	Have you ever had problems with your ears, such as ringing or change or hearing?
36.	________	_______	Do you feel your bite is closed?
37.	________	_______	Does pain or discomfort from your jaw joint interfere with your work or other activities?
38.	________	_______	Are there times when you notice that this problem or pain is less or gone completely?
39.	________	_______	Do you feel depressed?
40.	________	_______	Have you ever seen a psychologist for treatment?
41.	________	_______	Do you have a problem with insomnia?
42.	________	_______	Are you under a great deal of stress? Job, family, social, school…
43.	________	_______	Do you take more than one alcoholic drink per day?
44.	________	_______	Do you smoke cigarettes, cigars or a pipe?
45.	________	_______	Do you bite your mails, tongue or lips?
46.	________	_______	Do you feel your pain is related to stress?
47.	________	_______	Do you have morning stiffness other than in the jaw?
48.	________	_______	Do you experience tenderness in muscles other than those in your head or neck more than half the time?
49.	________	_______	Over the past years have you had recurrent swelling of joints other than in your TMJ?

LIST the names of **ALL** health professionals you have seen for treatment.
Chronologically:

Name	Date Seen	Address	Phone#
1.			
2.			
3.			
4.			
5.			

LIST ALL medications you are now taking, or have taken, for this problem.

Dates	Name of Medication	Who Prescribed It

DESCRIBE the problem in your own words: