**TMJ & Sleep Apnea Center**

# Medical and Dental Health History

**Platinum Dental, Inc.**

Name of Medical Doctor: ______________________________ City: __________________ Phone: ( ) __________________

Date of last medical Exam: _______________ *(Female only)* Is there any possibility you are pregnant? No ☐ Yes ☐ ____Months

**Have you even had or do you have any of the following? Please check below.**

☐ Heart murmur
☐ Rheumatic fever
☐ Mitral Valve Prolapse
☐ Prosthetic joints / Heart Valves
☐ Pacemaker
☐ Heart problems: ______________
☐ High Blood Pressure
☐ Stroke, when: _______________
☐ Blood trouble, anemia, leukemia
☐ Excessive bleeding
☐ Hepatitis: A or B or C or other
☐ Diabetes: Type I or Type II

☐ Tired jaw muscles
☐ Dizziness/Loss of Balance
☐ Earaches
☐ Ringing in ears
☐ Ear stuffiness
☐ Jaw pain
☐ Neck pain
☐ Headaches/Facial Pain
☐ Clenching/Grinding
☐ Change in bite
☐ Jaw locking/catching
☐ Jaw clicking/popping

☐ Lung trouble (TB, asthma, emphysema)
☐ Kidney disease: ______________________
☐ Arthritis, Degenerative joint disease
☐ Fainting spells, epilepsy, convulsions
☐ Nervous breakdown/ anxiety disorders
☐ Indium, cobalt or Lithium treatment
☐ Radiation or chemotherapy
☐ Tumor or cancer
☐ Shortness of Breath
☐ Venereal disease
☐ AIDS related complex
☐ Other: _____________________________

**Are you now taking medicines for: (please specify medication)**

☐ Pain ______________________
☐ Headaches __________________
☐ Arthritis ____________________
☐ Allergy (asthma) _____________
☐ Stomach (ulcers) _____________
☐ Thyroid ____________________
☐ Other ______________________________________________

☐ Heart _______________
☐ Nerves ______________
☐ Sleeping ____________
☐ Blood (thinners)______
☐ GERD _______________
☐ Birth Control ________

**Have you ever been allergic to, been sick from, or been told not to take:**

☐ Latex: ______________________________
☐ Metals: _____________________________
☐ Antibiotics (Penicillin, other): _________________________
☐ Narcotics (Codeine, other): ____________________________
☐ Aspirin, NSAIDS: _____________________________________
☐ Anesthetics (Novocaine, other): ________________________
☐ Other medications: ___________________________________

**Do you have any disease conditions, or problems that are not mentioned above?** _________________________________
**Do you smoke?** No ☐ Yes ☐ **If yes, how many cigarettes a day?** __________ **How many years?** ___________________
**Have you ever taken the diet drug combination, Fen-Phen?** No ☐ Yes ☐ other **diet drugs?** _________________________

Referring Doctor's Name:________________________________________________ City:______________________________

**Have you ever had or do you have any of the following?**

☐ Orthodontic treatment _________________
☐ Dental extractions ____________________
☐ Periodontal treatment _________________
☐ Gum surgery _________________________
☐ Dental implants _______________________
☐ Gum disease _________________________
☐ Endodontics/Root canals ______________
☐ Mouth guards/Sports guards____________
☐ Night guards _________________________
☐ Teeth whitening ______________________
☐ Sleep dentistry/general anesthesia/laughing gas
☐ Fear or anxiety related to dental treatment

**What is the reason you are seeking TMJ care now?**

☐ Jaw Pain
☐ Closed Lock
☐ Open Lock
☐ Reduced/Deviated Range of Motion
☐ Popping/Clicking
☐ Headaches
☐ Stuffiness/Tinnitus
☐ Other:________________

**What is your perceived level of pain/discomfort you are having now?**
☐ None ☐ Mild ☐ Moderate ☐Severe

**Have you gone anywhere else for your TMJ care?** ☐ Yes ☐ No
If yes, where?_____________________________________

**Are you undergoing any Dental care currently?** ☐ Yes ☐ No

I, the undersigned, have given the above information, have reviewed it and find it accurate. If there are any later changes, I will so inform the practice.
Patient Signature: _____________________________________________Date: _________________________

Patient Name (please print): __________________________________________________________________