



PATIENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

1. Are you allergic to any medicines, latex, eggs, or soybeans? *List any medication and reaction to medication.* \_\_\_\_\_  YES  NO
2. Do you take any medications (prescription or over-the-counter), supplements, or herbal therapy regularly now? *List name, strength, & frequency of current medications:* \_\_\_\_\_  
\_\_\_\_\_  YES  NO
3. Have you been a patient in a hospital during the past 2 years? .....  YES  NO
4. Are you now or have you been under the care of a physician during the past 2 years? .....  YES  NO
5. Have you ever had any type of surgery? *Please list:* \_\_\_\_\_  
\_\_\_\_\_  YES  NO
6. Have you had excessive bleeding requiring Special treatment? .....  YES  NO
7. Are you pregnant? .....  YES  NO
8. Have you ever had an artificial joint placed? .....  YES  NO
9. Do you get regular exercise? .....  YES  NO
10. Do you use or have you used tobacco products? .....  YES  NO
11. Do you use recreational drugs? .....  YES  NO
12. Do you drink alcohol? (Number of drinks per week \_\_\_\_\_ ) .....  YES  NO

**CHECK YES OR NO AS TO WHETHER YOU NOW OR IN THE PAST HAVE HAD PROBLEMS WITH AND/OR TREATMENT FOR:**

- |   |  |   |
|---|--|---|
| <input type="radio"/> YES <input type="radio"/> NO Heart Trouble            | <input type="radio"/> YES <input type="radio"/> NO Jaundice                      | <input type="radio"/> YES <input type="radio"/> NO Chemo / Radiation        |
| <input type="radio"/> YES <input type="radio"/> NO Asthma                   | <input type="radio"/> YES <input type="radio"/> NO Kidney Disease                | <input type="radio"/> YES <input type="radio"/> NO Chronic Fatigue          |
| <input type="radio"/> YES <input type="radio"/> NO Arthritis                | <input type="radio"/> YES <input type="radio"/> NO Alcohol Use                   | <input type="radio"/> YES <input type="radio"/> NO Chronic Pain             |
| <input type="radio"/> YES <input type="radio"/> NO Breathing Disorder       | <input type="radio"/> YES <input type="radio"/> NO HIV                           | <input type="radio"/> YES <input type="radio"/> NO Nasal Allergies          |
| <input type="radio"/> YES <input type="radio"/> NO Congenital Heart Defects | <input type="radio"/> YES <input type="radio"/> NO Immune System Disorder        | <input type="radio"/> YES <input type="radio"/> NO Meniere's Disease        |
| <input type="radio"/> YES <input type="radio"/> NO Stroke                   | <input type="radio"/> YES <input type="radio"/> NO TMJ Disorder                  | <input type="radio"/> YES <input type="radio"/> NO Muscular Dystrophy       |
| <input type="radio"/> YES <input type="radio"/> NO Heart Murmur             | <input type="radio"/> YES <input type="radio"/> NO Coronary Disease              | <input type="radio"/> YES <input type="radio"/> NO MS                       |
| <input type="radio"/> YES <input type="radio"/> NO Diabetes                 | <input type="radio"/> YES <input type="radio"/> NO Anxiety / Depression          | <input type="radio"/> YES <input type="radio"/> NO Osteoporosis             |
| <input type="radio"/> YES <input type="radio"/> NO Epilepsy                 | <input type="radio"/> YES <input type="radio"/> NO Difficulty Sleeping/ Insomnia | <input type="radio"/> YES <input type="radio"/> NO Parkinson's              |
| <input type="radio"/> YES <input type="radio"/> NO High Blood Pressure      | <input type="radio"/> YES <input type="radio"/> NO Fibromyalgia                  | <input type="radio"/> YES <input type="radio"/> NO Sleep Apnea              |
| <input type="radio"/> YES <input type="radio"/> NO Low Blood Pressure       | <input type="radio"/> YES <input type="radio"/> NO Excessive Daytime Sleepiness  | <input type="radio"/> YES <input type="radio"/> NO Orthodontic Treatment    |
| <input type="radio"/> YES <input type="radio"/> NO Tuberculosis             | <input type="radio"/> YES <input type="radio"/> NO Glaucoma                      | <input type="radio"/> YES <input type="radio"/> NO Rheumatoid Arthritis     |
| <input type="radio"/> YES <input type="radio"/> NO Psychiatric Treatment    | <input type="radio"/> YES <input type="radio"/> NO Gout                          | <input type="radio"/> YES <input type="radio"/> NO Thyroid Disorder         |
| <input type="radio"/> YES <input type="radio"/> NO Anemia                   | <input type="radio"/> YES <input type="radio"/> NO Hemophilia                    | <input type="radio"/> YES <input type="radio"/> NO Recurrent Ear Infections |
| <input type="radio"/> YES <input type="radio"/> NO Hepatitis                | <input type="radio"/> YES <input type="radio"/> NO Cancer                        | <input type="radio"/> YES <input type="radio"/> NO Urinary Disorders        |
| <input type="radio"/> YES <input type="radio"/> NO Sinus Trouble            |  | <input type="radio"/> YES <input type="radio"/> NO Tumors                   |
| <input type="radio"/> YES <input type="radio"/> NO Rheumatic Fever          |  |   |

### OTHER SYMPTOMS

- |  |  |  |
|--|--|--|
| <input type="radio"/> YES <input type="radio"/> NO Teeth Grinding      | <input type="radio"/> YES <input type="radio"/> NO Feeling of Foreign Object in Throat | <input type="radio"/> YES <input type="radio"/> NO Skin Lesions                            |
| <input type="radio"/> YES <input type="radio"/> NO Teeth Clenching     | <input type="radio"/> YES <input type="radio"/> NO Swelling in Neck                    | <input type="radio"/> YES <input type="radio"/> NO Muscle Weakness or Paralysis            |
| <input type="radio"/> YES <input type="radio"/> NO Dry Mouth           | <input type="radio"/> YES <input type="radio"/> NO Shoulder Pain                       | <input type="radio"/> YES <input type="radio"/> NO Nail Malformations                      |
| <input type="radio"/> YES <input type="radio"/> NO Broken Teeth        | <input type="radio"/> YES <input type="radio"/> NO Burning Tongue                      | <input type="radio"/> YES <input type="radio"/> NO Fibromyalgia                            |
| <input type="radio"/> YES <input type="radio"/> NO Ear Pain            | <input type="radio"/> YES <input type="radio"/> NO Snoring                             | <input type="radio"/> YES <input type="radio"/> NO Numbness / Tingling in Hands or Fingers |
| <input type="radio"/> YES <input type="radio"/> NO Ear Congestion      | <input type="radio"/> YES <input type="radio"/> NO Tightness in Throat                 |  |
| <input type="radio"/> YES <input type="radio"/> NO Blurred Vision      | <input type="radio"/> YES <input type="radio"/> NO Joint Stiffness                     |  |
| <input type="radio"/> YES <input type="radio"/> NO Eye Pain            | <input type="radio"/> YES <input type="radio"/> NO Headaches                           |  |
| <input type="radio"/> YES <input type="radio"/> NO Chronic Sore Throat |  |  |

### REVIEW OF SYMPTOMS IN THE LAST 2 WEEKS

- |  |   |   |
|--|---|---|
| <input type="radio"/> YES <input type="radio"/> NO Appetite Changes          | <input type="radio"/> YES <input type="radio"/> NO Swallowing Difficulty    | <input type="radio"/> YES <input type="radio"/> NO Bruising Easily      |
| <input type="radio"/> YES <input type="radio"/> NO Marked Weight Changes     | <input type="radio"/> YES <input type="radio"/> NO Ulcers or Lumps in Mouth | <input type="radio"/> YES <input type="radio"/> NO Arrhythmia           |
| <input type="radio"/> YES <input type="radio"/> NO Night Sweating            | <input type="radio"/> YES <input type="radio"/> NO Sore Gums or Tongue      | <input type="radio"/> YES <input type="radio"/> NO Heart Burn           |
| <input type="radio"/> YES <input type="radio"/> NO Recent Trauma / Infection | <input type="radio"/> YES <input type="radio"/> NO Neck Pain                | <input type="radio"/> YES <input type="radio"/> NO Back Pain            |
| <input type="radio"/> YES <input type="radio"/> NO Tire Easily               | <input type="radio"/> YES <input type="radio"/> NO Neck Stiffness           | <input type="radio"/> YES <input type="radio"/> NO Muscle Cramps / Pain |
| <input type="radio"/> YES <input type="radio"/> NO Ringing in Ears           | <input type="radio"/> YES <input type="radio"/> NO Persistent Cough         | <input type="radio"/> YES <input type="radio"/> NO Dizziness            |
| <input type="radio"/> YES <input type="radio"/> NO Sinus Infection           | <input type="radio"/> YES <input type="radio"/> NO Wheezing                 | <input type="radio"/> YES <input type="radio"/> NO Increased Thirst     |
| <input type="radio"/> YES <input type="radio"/> NO Sore Throat / Hoarseness  | <input type="radio"/> YES <input type="radio"/> NO Shortness of Breath      | <input type="radio"/> YES <input type="radio"/> NO Heat Intolerance     |
|  | <input type="radio"/> YES <input type="radio"/> NO Swelling of Ankles       | <input type="radio"/> YES <input type="radio"/> NO Cold Intolerance     |
|  |   | <input type="radio"/> YES <input type="radio"/> NO Increased Urination  |

1. Do you have any medical or dental problems?  YES  NO Explain: \_\_\_\_\_

2. Over the past two weeks, how often have you felt the following problems?

*Not at All = 0, Several Days = 1, More than Half the Days = 2, Nearly Every Day = 3*

Feeling nervous, anxious, or on edge \_\_\_\_\_ Not being able to stop or control worrying \_\_\_\_\_

Feeling down, depressed, or hopeless \_\_\_\_\_ Little pleasure or interest in doing things \_\_\_\_\_

3. Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in each situation?

*0 = No Chance of Dozing, 1 = Slight Chance, 2 = Moderate Chance, 3 = High Chance*

Sitting & reading \_\_\_\_\_ Watching TV \_\_\_\_\_ Sitting inactive in public (ie theater) \_\_\_\_\_

Passenger in a car (1 hr.+) \_\_\_\_\_ Lying down in the afternoon \_\_\_\_\_ Sitting and talking to someone \_\_\_\_\_

Sitting quietly after lunch \_\_\_\_\_ In a car, while stopped for a few minutes in traffic \_\_\_\_\_

### WITH HEADACHES, DO YOU EXPERIENCE ANY OF THE FOLLOWING?

- |   |   |   |
|---|---|---|
| <input type="radio"/> YES <input type="radio"/> NO Aura                 | <input type="radio"/> YES <input type="radio"/> NO Agitation              | <input type="radio"/> YES <input type="radio"/> NO Eyes Drooping          |
| <input type="radio"/> YES <input type="radio"/> NO Sensitivity to Noise | <input type="radio"/> YES <input type="radio"/> NO Burning                | <input type="radio"/> YES <input type="radio"/> NO Swelling               |
| <input type="radio"/> YES <input type="radio"/> NO Sensitivity to Light | <input type="radio"/> YES <input type="radio"/> NO Double Vision          | <input type="radio"/> YES <input type="radio"/> NO Congestion/ Runny Nose |
| <input type="radio"/> YES <input type="radio"/> NO Fatigue              | <input type="radio"/> YES <input type="radio"/> NO Vomiting               | <input type="radio"/> YES <input type="radio"/> NO Nausea                 |
| <input type="radio"/> YES <input type="radio"/> NO Dizziness            | <input type="radio"/> YES <input type="radio"/> NO Restlessness / Anxiety |   |
| <input type="radio"/> YES <input type="radio"/> NO Throbbing            | <input type="radio"/> YES <input type="radio"/> NO Redness                |   |

Which side are the headaches worse?  LEFT  RIGHT Where does the headache spread? \_\_\_\_\_

How many headache days per month? \_\_\_\_\_

**CHIEF COMPLAINT**

What information is important regarding the pain or condition that brings you here? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Frequency and Duration of chief complaint pain? \_\_\_\_\_  
\_\_\_\_\_

Describe the pain (Ex: Burning, Aching, Throbbing, Sore, Pressure, Sharp, Dull, Shooting) \_\_\_\_\_

Is there anything that makes your pain/discomfort worse? \_\_\_\_\_

Is there anything that makes your pain or discomfort better? \_\_\_\_\_

1. Rate your level of pain from 0 – 10, with 0 = None At All and 10 = Worst Possible

	TMJ	FACE	HEADACHE
PAIN AT THIS MOMENT			
PAIN AVERAGE IN 6 MONTHS			
PAIN AT WORST LEVEL			

2. On a scale of 0 – 10, 0 = No Interference and 10 = Unable to Carry on Activities, how much has pain interfered with daily life?

Please explain it interferes? \_\_\_\_\_  
\_\_\_\_\_

Was there a prior accident/fall/trauma to the area of pain?  YES  NO Explain: \_\_\_\_\_

Were there prior tests?  YES  NO Explain: \_\_\_\_\_

Was there prior treatments?  YES  NO Explain: \_\_\_\_\_

**WHAT TYPE OF TREATMENT HAVE YOU HAD FOR THIS PAIN/PROBLEM?**

Medicines: \_\_\_\_\_

Counseling: \_\_\_\_\_

Occlusal Adjustments: \_\_\_\_\_

Splint: Yes No How Many? \_\_\_\_\_

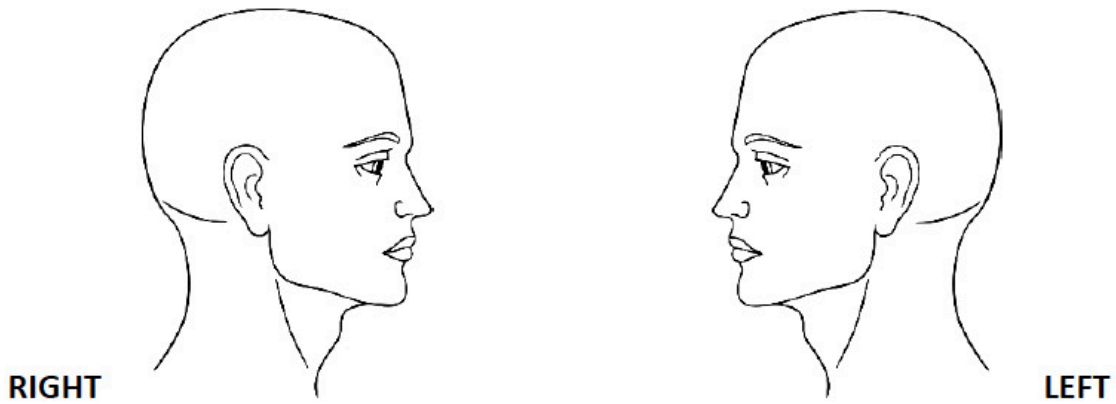
Orthodontics: \_\_\_\_\_

Physical Therapy: \_\_\_\_\_

Other: \_\_\_\_\_

**DRAW ON THE IMAGES THE AREAS THAT ARE PAINFUL:**

*(If filling out on a computer, use space and enter keys to place an X over the area.)*



**ALL COMPLETED FORMS SHOULD BE EMAILED TO [GREENVILLE@MYCENTERS.COM](mailto:GREENVILLE@MYCENTERS.COM).**