CAROLINAS CENTER FOR
Oral & Facial Surgery

MEDICAL HISTORY

Name of Patient: _____ 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? ..... ☐ Yes ☐ No

   List name, strength, & frequency of current medications: _____

   _____

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? (List below.) ..... ☐ 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:

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

OTHER SYMPTOMS

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

REVIEW OF SYMPTOMS IN THE LAST 2 WEEKS

☐ YES ☐ NO Appetite Changes	☐ YES ☐ NO Marked Weight Changes	☐ YES ☐ NO Night Sweating
☐ YES ☐ NO Recent Trauma / Infection	☐ YES ☐ NO Tire Easily	☐ YES ☐ NO Ringing in Ears
☐ YES ☐ NO Sinus Infection	☐ YES ☐ NO Sore Throat / Hoarseness	☐ YES ☐ NO Swallowing Difficulty
☐ YES ☐ NO Ulcers or Lumps in Mouth	☐ YES ☐ NO Sore Gums or Tongue	☐ YES ☐ NO Neck Pain
☐ YES ☐ NO Neck Stiffness	☐ YES ☐ NO Persistent Cough	☐ YES ☐ NO Wheezing
☐ YES ☐ NO Shortness of Breath	☐ YES ☐ NO Swelling of Ankles	☐ YES ☐ NO Bruising Easily
☐ YES ☐ NO Arrhythmia	☐ YES ☐ NO Heart Burn	☐ YES ☐ NO Back Pain
☐ YES ☐ NO Muscle Cramps / Pain	☐ YES ☐ NO Dizziness	☐ YES ☐ NO Increased Thirst
☐ YES ☐ NO Heat Intolerance	☐ YES ☐ NO Cold Intolerance	☐ YES ☐ 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. Rate your level of pain from 0 – 10, with 0 = None At All and 10 = Worst Possible
   - TMJ, Facial Pain, or Headache at this moment? _____
   - Worst level in the past 6 months? _____
   - Average pain level in the past 6 months? _____

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

5. 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 and 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 _____
   - Driving while stopped in traffic _____

With Headaches, do you experience any of the following?

☐ YES ☐ NO Aura	☐ YES ☐ NO Sensitivity to Noise	☐ YES ☐ NO Sensitivity to Light	☐ YES ☐ NO Fatigue
☐ YES ☐ NO Dizziness	☐ YES ☐ NO Throbbing	☐ YES ☐ NO Agitation	☐ YES ☐ NO Burning
☐ YES ☐ NO Double Vision	☐ YES ☐ NO Vomiting	☐ YES ☐ NO Restlessness / Anxiety	☐ YES ☐ NO Redness
☐ YES ☐ NO Eyes Drooping	☐ YES ☐ NO Swelling	☐ YES ☐ NO Congestion/Runny Nose	☐ YES ☐ NO Nausea

Which side are the headaches worse? ☐ Left ☐ Right Where does the headache spread? _____

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

Is there anything that makes your pain/discomfort worse? _____

What other information is important regarding the pain or condition that brings you here? _____

_____

How many headache days per month? _____ Frequency? _____ Duration? _____

Is there anything that makes your pain or discomfort better? _____

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

Was there prior treatment? ☐ YES ☐ NO Explain: _____

What type of treatment have you had for this pain/problem?

Medicines: _____

Counseling: _____

Occlusal Adjustments: _____

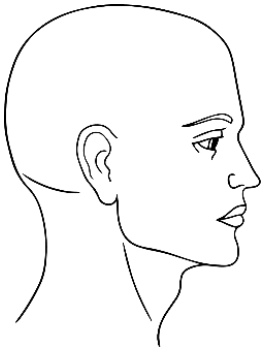
Splint: ☐ Yes ☐ No How Many? _____

Orthodontics: _____

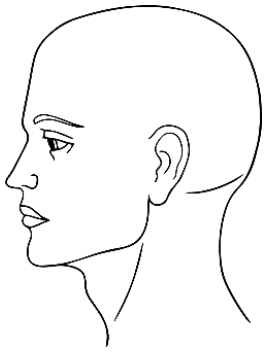
Physical Therapy: _____

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.)



RIGHT



LEFT

All completed forms should be emailed to Greenville@mycenters.com.