602-612-2435
6226 N 27th Ave, Phoenix, AZ 85017

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the best treatment. Please take your time and answer each question as completely and honestly as possible.

PATIENT INFORMATION

TODAY'S DATE: _____

☐MR. ☐MS ☐MISS ☐MRS. ☐DR. Name: _____
FIRST MIDDLE INITIAL LAST

AGE: _____ DATE OF BIRTH: _____ ☐MALE ☐FEMALE

ADDRESS:_____ CITY/STATE/ZIP: _____

E-MAIL ADDRESS: _____

MOBILE TELEPHONE NUMBER: _____

HOW LONG AT CURRENT ADDRESS? _____ (IF LESS THAN 3 YEARS, PLEASE GIVE PREVIOUS ADDRESS.)

PREVIOUS ADDRESS: _____

EMPLOYED BY: _____OCCUPATION: _____

ADDRESS: _____

REFERRED BY: _____

SS#: _____HOME PHONE: _____WORK PHONE: _____

ADDRESS IF DIFFERENT FROM PATIENT: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____

FAMILY DENTIST/Previous Dentist: _____

ADDRESS: _____

602-612-2435
6226 N 27th Ave, Phoenix, AZ 85017

DO ANY OF THE FOLLOWING CHIEF COMPLAINTS APPLY TO YOU?

Y ☐ N ☐ Diet limited to semisolid or soft foods
Y ☐ N ☐ Mouth sores
Y ☐ N ☐ Diet limited to liquid foods
Y ☐ N ☐ Numbness in lower lip
Y ☐ N ☐ Difficulty chewing
Y ☐ N ☐ Numbness in jawbone
Y ☐ N ☐ Difficulty speaking
Y ☐ N ☐ Tingling in jawbone
Y ☐ N ☐ Nutritional disorders
Y ☐ N ☐ Digestive problems
Y ☐ N ☐ Pain in jaw bone
Y ☐ N ☐ Facial pain
Y ☐ N ☐ Are you currently in pain? _____
Y ☐ N ☐ Do you feel your oral condition is affecting your general health in any way? _____

Y ☐ N ☐ Jaw locks
Upper Lower
Y ☐ N ☐ Limited opening of jaw
Y ☐ N ☐ Teeth do not meet properly
Y ☐ N ☐ Loss of teeth
Y ☐ N ☐ Poorly fitting dental appliance
Y ☐ N ☐ Pain in jaw joint
Y ☐ N ☐ Gagging easily
Y ☐ N ☐ Pain when swallowing
Y ☐ N ☐ Head pain
Y ☐ N ☐ Jaw clicks
Y ☐ N ☐ Other

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y ☐ N ☐ Antibiotics
Y ☐ N ☐ Aspirin
Y ☐ N ☐ Barbiturates
Y ☐ N ☐ Codeine
Y ☐ N ☐ Lidocaine
Y ☐ N ☐ Latex

Y ☐ N ☐ Metals
Y ☐ N ☐ Plastic
Y ☐ N ☐ Sedative
Y ☐ N ☐ Sleeping pill
Y ☐ N ☐ Local anesthetics
Y ☐ N ☐ Other

LIST MEDICATIONS/SUBSTANCES YOU ARE CURRENTLY TAKING:

Y ☐ N ☐ Antibiotics
Y ☐ N ☐ Insulin
Y ☐ N ☐ Anticoagulants
Y ☐ N ☐ Muscle Relaxants
Y ☐ N ☐ Barbiturates
Y ☐ N ☐ Nerve pills
Y ☐ N ☐ Blood thinners
Y ☐ N ☐ Pain medication
Y ☐ N ☐ Codeine
Y ☐ N ☐ Sleeping pills
Y N Other _____

Y ☐ N ☐ Cortisone
Y ☐ N ☐ Sulfa Drugs
Y ☐ N ☐ Ginko Biloba
Y ☐ N ☐ Diet pills
Y ☐ N ☐ Heart medication
Y ☐ N ☐ Tranquilizers
Y ☐ N ☐ Medications for osteoporosis
Y ☐ N ☐ Bisphosphonates
Y ☐ N ☐ Herbal supplements

602-612-2435
6226 N 27th Ave, Phoenix, AZ 85017

MEDICAL HISTORY (Please indicate dates on questions checked YES)

Y ☐ N ☐ Abnormal bleeding after surgery/Injury
Y ☐ N ☐ Anemia
Y ☐ N ☐ Allergic Rhinitis
Y ☐ N ☐ Arteriosclerosis
Y ☐ N ☐ Asthma
Y ☐ N ☐ Autoimmune disorders
Y ☐ N ☐ Bleeding easily
Y ☐ N ☐ Bloating
Y ☐ N ☐ Blood pressure ☐ High ☐ Low
Y ☐ N ☐ Bruising easily
Y ☐ N ☐ Cancer
Y ☐ N ☐ Chemotherapy
Y ☐ N ☐ Chronic Bronchitis
Y ☐ N ☐ Chronic fatigue
Y ☐ N ☐ Chronic mouth dryness
Y ☐ N ☐ Cold hands & feet
Y ☐ N ☐ Colitis
Y ☐ N ☐ Current pregnancy
Y ☐ N ☐ Depression
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Dizziness
Y ☐ N ☐ Emphysema
Y ☐ N ☐ Epilepsy
Y ☐ N ☐ Excessive thirst
Y ☐ N ☐ Fainting spells
Y ☐ N ☐ Fluid retention
Y ☐ N ☐ Frequent cough
Y ☐ N ☐ Frequent illnesses
Y ☐ N ☐ Frequent stressful situations
Y ☐ N ☐ Glaucoma
Y ☐ N ☐ Gout
Y ☐ N ☐ Hay fever
Y ☐ N ☐ Headaches
Y ☐ N ☐ Hearing impairment
Y ☐ N ☐ Heart murmur
Y ☐ N ☐ Injury to
☐ Face ☐ Neck ☐ Mouth ☐ Teeth
Y ☐ N ☐ Extra pillows to help breathing at night
Y ☐ N ☐ Tumors
Y ☐ N ☐ Urinary Disorders

Y ☐ N ☐ Heart disorder
Y ☐ N ☐ Heart pacemaker
Y ☐ N ☐ Heart valve replacement
Y ☐ N ☐ Hemophilia
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ Hypoglycemia
Y ☐ N ☐ Immune system disorder
Y ☐ N ☐ Insomnia
Y ☐ N ☐ Intestinal disorders
Y ☐ N ☐ Jaw joint surgery
Y ☐ N ☐ Kidney problems
Y ☐ N ☐ Liver disease
Y ☐ N ☐ Menstrual cramps
Y ☐ N ☐ Multiple sclerosis
Y ☐ N ☐ Muscle aches
Y ☐ N ☐ Muscle shaking (tremors)
Y ☐ N ☐ Muscle spasms or cramps
Y ☐ N ☐ Muscula dystrophy
Y ☐ N ☐ Nasal Stuffiness in the morning
Y ☐ N ☐ Nervousness
Y ☐ N ☐ Neuralgia
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Ovarian cysts
Y ☐ N ☐ Parkinson's disease
Y ☐ N ☐ Poor circulation
Y ☐ N ☐ Prior orthodontic treatment
Y ☐ N ☐ Psychiatric treatment
Y ☐ N ☐ Rheumatoid arthritis
Y ☐ N ☐ Rheumatic fever
Y ☐ N ☐ Scarlet Fever
Y ☐ N ☐ Seizures
Y ☐ N ☐ Shortness of breath
Y ☐ N ☐ Slow healing sores
Y ☐ N ☐ Sickle Cell Anemia
Y ☐ N ☐ Sinus problems
Y ☐ N ☐ Speech difficulties
Y ☐ N ☐ Stomach ulcers
Y ☐ N ☐ Stroke
Y ☐ N ☐ Swelling of ankles
Y ☐ N ☐ Tendency for frequent colds
Y ☐ N ☐ Tuberculosis

Y ☐ N ☐ Other Medical/Dental History _____

602-612-2435
6226 N 27th Ave, Phoenix, AZ 85017

PLEASE LIST OTHER HEALTHCARE PRACTITIONERS SEEN IN THE LAST 9 MONTHS:

Practitioner Specialty Treatment & Approximate Date

_____

_____

_____

Do you take aspirin regularly ☐YES ☐NO Smoke tobacco ☐YES ☐NO

Has any close relative had a serious illness or condition? _____

Emotional or nervous disturbances? ☐YES ☐NO

If yes, please explain: _____

_____

_____

_____

Patient Signature:_____ **Date:**_____