LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

Y☐ N☐ Antibiotics
Y☐ N☐ Anticoagulants
Y☐ N☐ Blood thinners
Y☐ N☐ Codeine
Y☐ N☐ Cortisone
Y☐ N☐ Diet pills
Y☐ N☐ Heart medication
Y☐ N☐ Insulin
Y☐ N☐ Muscle relaxants
Y☐ N☐ Pain medication
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs

Other current medications: _____

MEDICAL HISTORY

Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Blood pressure ☐High ☐Low
Y☐ N☐ Cancer
Y☐ N☐ Chemotherapy
Y☐ N☐ Chronic fatigue
Y☐ N☐ Current pregnancy
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Fibromyalgia
Y☐ N☐ Frequent snoring
Y☐ N☐ Hay fever
Y☐ N☐ Hearing impairment
Y☐ N☐ Heart murmur
Y☐ N☐ Heart disorder
Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart valve replacement
Y☐ N☐ Hemophilia
Y☐ N☐ Hepatitis
Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to ☐ Face ☐ Neck ☐ Teeth ☐ Head ☐ Mouth
Y☐ N☐ Insomnia
Y☐ N☐ Intestinal disorders
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Meniere's disease
Y☐ N☐ Migraines
Y☐ N☐ Multiple sclerosis
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Radiation treatment
Y☐ N☐ Rheumatic fever
Y☐ N☐ Rheumatoid arthritis
Y☐ N☐ Scarlet fever
Y☐ N☐ Shortness of breath
Y☐ N☐ Sinus problems
Y☐ N☐ Sleep Apnea
Y☐ N☐ Speech difficulties
Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Teeth clenching or grinding
Y☐ N☐ Wisdom teeth extraction

Other medical history:
_____
_____

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

L= Left R=Right B=Both sides

HEAD PAIN	LOCATION	SEVERITY: MILD	SEVERITY: MODERATE	SEVERITY: SEVERE	FREQUENCY: OCCASIONAL (MONTHLY OR LESS)	FREQUENCY: FREQUENT (WEEKLY)	FREQUENCY: CONSTANT (EVERY DAY)	DURATION: SECONDS	DURATION: MINUTES	DURATION: HOURS	DURATION: DAYS	DURATION: WEEKS
L R B	Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

HISTORY OF SYMPTOMS

When did your condition first occur? _____

What do you believe to be the cause of your pain or condition? _____

Y☐ N☐ Motor vehicle accident
Y☐ N☐ Motorcycle accident
Y☐ N☐ Work related incident
Y☐ N☐ Playground incident
Y☐ N☐ Athletic endeavor
Y☐ N☐ Fight
Y☐ N☐ Fall
Y☐ N☐ Accident
Y☐ N☐ Illness
Y☐ N☐ Injury
Y☐ N☐ Unknown

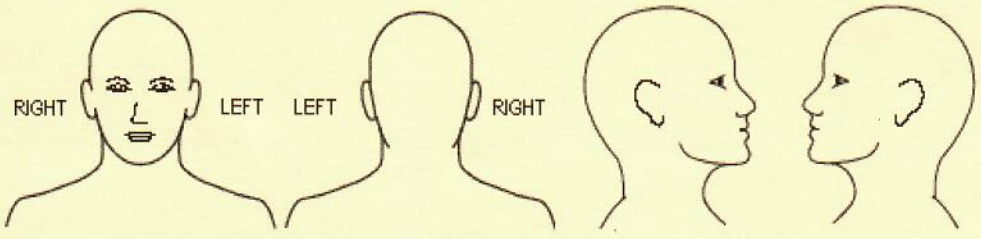
If accident, what was the date? _____

What other information is important to your pain or condition? _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN ||||||
MODERATE PAIN ^^^^
SEVERE PAIN ////////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating



I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature _____ Date _____