

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			FREQUENCY			DURATION				
		MODERATE		OCCASIONAL (MONTHLY OR LESS)	CONSTANT (EVERY DAY)	MINUTES		DAYS				
		MILD	SEVERE			FREQUENT (WEEKLY)	SECONDS	HOURS	WEEKS			
L R B	Front of your head (Frontal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Entire head (Generalized)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Top of your head (Parietal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Back of your head (Occipital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	In your temples (Temporal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HISTORY OF SYMPTOMS

When did your condition first occur? _____

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

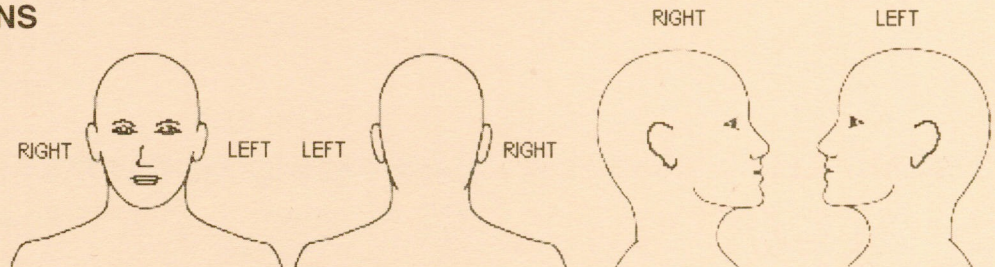
- Y N Motor vehicle accident
- Y N Motorcycle accident
- Y N Work related incident
- Y N Playground incident
- Y N Athletic endeavor
- Y N Fight
- Y N Fall
- Y N Accident
- Y N Illness
- Y N Injury
- Y N Unknown

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 _____