

THIS QUESTIONNAIRE IS DESIGNED TO PROVIDE IMPORTANT FACTS REGARDING THE HISTORY OF YOUR PRESENT CONDITION. THE INFORMATION YOU PROVIDE WILL ASSIST IN REACHING A DIAGNOSIS AND DETERMINING THE SOURCE OF YOUR PROBLEM. PLEASE TAKE YOUR TIME ANSWERING EACH QUESTION AS COMPLETELY AND HONESTLY AS POSSIBLE.

**1. PLEASE INDICATE ANY OF THE FOLLOWING YOU ARE NOW EXPERIENCING OR HAVE EXPERIENCED IN THE PAST:**

**HEAD/FACE**

- Forehead headaches
- Temporal headaches
- Tension headaches
- Migraine-type headaches
- Sinus headaches
- Back of head headaches
- Scalp tender to touch

**EARS**

- Ear pain without infection
- Decreased hearing
- Clogged/stuffy feeling in ear(s)
- Itchy feeling in ear(s)
- Ringing/buzzing in ear(s)
- Dizziness
- Balance problems

**THROAT**

- Difficulty swallowing
- Feeling of foreign object in throat
- Sore throat without infection
- Voice changes
- Laryngitis
- Frequent coughing or clearing

**NECK**

- Lack of mobility
- Stiffness
- Neck pain
- Tired/sore neck muscles
- Shoulder pain
- Back pain
- Arm/finger pain or numbness

**EYES**

- Pain in/around eyes
- Bloodshot eyes
- Sensitivity to light
- Tearing of eyes
- Blurred vision
- Pressure behind eyes
- Dark circles under eyes

**NASAL**

- Sinus pain
- Sinus problems
- Post-nasal drainage
- Allergies

**JAW**

- Jaw pain
- Jaw joint pain
- Clicking/popping in jaw joint(s)
- Grinding sound in jaw joint(s)
- Pain in cheek muscles
- Uncontrollable jaw movements
- Jaw locks open/shut
- Deviation of jaw to one side

**MOUTH**

- Abnormal opening
- Limited opening
- Bad bite
- Missing teeth
- Clenching/grinding teeth
- Mouth discomfort
- Inability to find bite
- Burning tongue
- Sour or foul taste in mouth

**SLEEP**

- Snoring
- Sleep apnea
- Have been told I snore
- Have been told I stop breathing
- Have awoken gasping for air

**2. WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING CARE? PLEASE ORDER COMPLAINTS BY NUMBER (1=MOST IMPORTANT, 10=LEAST)**

<input type="checkbox"/> THROAT PAIN	<input type="checkbox"/> BACK PAIN	<input type="checkbox"/> PAIN BEHIND EYES	<input type="checkbox"/> VISUAL DISTURBANCES
<input type="checkbox"/> JAW CLICKING	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> PAIN WHEN CHEWING	<input type="checkbox"/> SINUS CONGESTION
<input type="checkbox"/> JAW JOINT NOISE	<input type="checkbox"/> EAR PAIN	<input type="checkbox"/> RINGING IN EARS	<input type="checkbox"/> MUSCLE TWITCHING
<input type="checkbox"/> JAW LOCKING	<input type="checkbox"/> FACIAL PAIN	<input type="checkbox"/> SHOULDER PAIN	<input type="checkbox"/> INABILITY TO OPEN MOUTH
<input type="checkbox"/> JAW PAIN	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> LIMITED MOUTH OPENING	<input type="checkbox"/> OTHER: <input type="text"/>
<input type="checkbox"/> NECK PAIN	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> EAR CONGESTION	<input type="checkbox"/> OTHER: <input type="text"/>

**3. PLEASE LIST TREATMENTS YOU HAVE RECEIVED, AS WELL AS HEALTH CARE PROFESSIONALS YOU HAVE SEEN.**

	PRACTICIONER	SPECIALTY	TREATMENT RECEIVED	APRX DATE
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**4. PLEASE INDICATE ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION**

**NO ALLERGIES**

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> ANTIBIOTICS  | <input type="checkbox"/> LATEX            | <input type="checkbox"/> SEDATIVES      |
| <input type="checkbox"/> ASPIRIN      | <input type="checkbox"/> LOCAL ANESTHETIC | <input type="checkbox"/> SLEEPING PILLS |
| <input type="checkbox"/> BARBITURATES | <input type="checkbox"/> METALS           | <input type="checkbox"/> SULFA DRUGS    |
| <input type="checkbox"/> CODEINE      | <input type="checkbox"/> PENICILLIN       | OTHER <input type="text"/>              |
| <input type="checkbox"/> IODINE       | <input type="checkbox"/> PLASTICS         | OTHER <input type="text"/>              |

**5. PLEASE LIST ALL MEDICATIONS CURRENTLY BEING TAKEN**

**NO MEDICATIONS**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ANTIBIOTICS    | <input type="checkbox"/> CORTISONE        | <input type="checkbox"/> NERVE PILLS     |
| <input type="checkbox"/> ANTICOAGULANTS | <input type="checkbox"/> DIET PILLS       | <input type="checkbox"/> PAIN MEDICATION |
| <input type="checkbox"/> BARBITURATES   | <input type="checkbox"/> HEART MEDICATION | <input type="checkbox"/> SLEEPING PILLS  |
| <input type="checkbox"/> BLOOD THINNERS | <input type="checkbox"/> INSULIN          | <input type="checkbox"/> SULFA DRUGS     |
| <input type="checkbox"/> CODEINE        | <input type="checkbox"/> MUSCLE RELAXANTS | <input type="checkbox"/> TRANQUILIZERS   |

- |                         |                          |
|-------------------------|--------------------------|
| 1. <input type="text"/> | 6. <input type="text"/>  |
| 2. <input type="text"/> | 7. <input type="text"/>  |
| 3. <input type="text"/> | 8. <input type="text"/>  |
| 4. <input type="text"/> | 9. <input type="text"/>  |
| 5. <input type="text"/> | 10. <input type="text"/> |

**6. PLEASE COMPLETE THE FOLLOWING MEDICAL/DENTAL HISTORY**

**DETAILS**

- |  |                      |
|--|----------------------|
| <input type="checkbox"/> ADENOIDS REMOVED?   | <input type="text"/> |
| <input type="checkbox"/> TONSILS REMOVED?    | <input type="text"/> |
| <input type="checkbox"/> ANEMIA              | <input type="text"/> |
| <input type="checkbox"/> ARTERIOSCLEROSIS    | <input type="text"/> |
| <input type="checkbox"/> ASTHMA              | <input type="text"/> |
| <input type="checkbox"/> AUTOIMMUNE DISORDER | <input type="text"/> |
| <input type="checkbox"/> BLEEDING EASILY     | <input type="text"/> |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="text"/> |
| <input type="checkbox"/> LOW BLOOD PRESSURE  | <input type="text"/> |
| <input type="checkbox"/> BRUISING EASILY     | <input type="text"/> |
| <input type="checkbox"/> CANCER              | <input type="text"/> |
| <input type="checkbox"/> CHEMOTHERAPY        | <input type="text"/> |
| <input type="checkbox"/> CHRONIC FATIGUE     | <input type="text"/> |
| <input type="checkbox"/> COLD HANDS/FEET     | <input type="text"/> |
| <input type="checkbox"/> CURRENT PREGNANCY   | <input type="text"/> |
| <input type="checkbox"/> DEPRESSION          | <input type="text"/> |
| <input type="checkbox"/> DIABETES            | <input type="text"/> |
| <input type="checkbox"/> DIFFICULTY FOCUSING | <input type="text"/> |
| <input type="checkbox"/> DIZZINESS           | <input type="text"/> |
| <input type="checkbox"/> EMPHYSEMA           | <input type="text"/> |
| <input type="checkbox"/> EPILEPSY            | <input type="text"/> |
| <input type="checkbox"/> EXCESSIVE THIRST    | <input type="text"/> |

<input type="checkbox"/>	FLUID RETENTION	
<input type="checkbox"/>	FREQUENT COUGH	
<input type="checkbox"/>	FREQUENT ILLNESS	
<input type="checkbox"/>	FREQUENT STRESS	
<input type="checkbox"/>	GENERAL ANESTHESIA	
<input type="checkbox"/>	GLAUCOMA	
<input type="checkbox"/>	GOUT	
<input type="checkbox"/>	HAY FEVER	
<input type="checkbox"/>	HEARING IMPAIRMENT	
<input type="checkbox"/>	HEART MURMUR	
<input type="checkbox"/>	HEART DISORDER	
<input type="checkbox"/>	HEART PACEMAKER	
<input type="checkbox"/>	HEART PALPITATIONS	
<input type="checkbox"/>	HEART VALVE REPL.	
<input type="checkbox"/>	HEMOPHILIA	
<input type="checkbox"/>	HEPATITIS	
<input type="checkbox"/>	HYPOGLYCEMIA	
<input type="checkbox"/>	IMMUNE DISORDER	
<input type="checkbox"/>	INJURY TO FACE	
<input type="checkbox"/>	INJURY TO NECK	
<input type="checkbox"/>	INJURY TO MOUTH	
<input type="checkbox"/>	INJURY TO TEETH	
<input type="checkbox"/>	INSOMNIA	
<input type="checkbox"/>	INTESTINAL DISORDER	
<input type="checkbox"/>	JAW JOINT SURGERY	
<input type="checkbox"/>	KIDNEY PROBLEMS	
<input type="checkbox"/>	LIVER DISEASE	
<input type="checkbox"/>	MENIERE'S DISEASE	
<input type="checkbox"/>	MENSTRUAL CRAMPS	
<input type="checkbox"/>	MULTIPLE SCLEROSIS	
<input type="checkbox"/>	MUSCLE ACHES	
<input type="checkbox"/>	MUSCLE TREMORS	
<input type="checkbox"/>	MUSCLE CRAMPS	
<input type="checkbox"/>	MUSCULAR DYSTROPHY	
<input type="checkbox"/>	NEED PILLOW AT NIGHT	
<input type="checkbox"/>	NERVOUS IRRITABILITY	
<input type="checkbox"/>	NERVOUSNESS	
<input type="checkbox"/>	NEURALGIA	
<input type="checkbox"/>	OSTEOPOROSIS	
<input type="checkbox"/>	PARKINSON'S DISEASE	
<input type="checkbox"/>	POOR CIRCULATION	
<input type="checkbox"/>	PRIOR ORTHODONTICS	
<input type="checkbox"/>	PSYCHIATRIC CARE	
<input type="checkbox"/>	RADIATION TREATMENT	
<input type="checkbox"/>	RHEUMATIC FEVER	
<input type="checkbox"/>	RHEUMATOID ARTHRITIS	
<input type="checkbox"/>	SCARLET FEVER	

<input type="checkbox"/>	SHORTNESS OF BREATH	
<input type="checkbox"/>	SINUS PROBLEMS	
<input type="checkbox"/>	SKIN DISORDERS	
<input type="checkbox"/>	SLOW HEALING SORES	
<input type="checkbox"/>	SPEECH DIFFICULTY	
<input type="checkbox"/>	STROKE	
<input type="checkbox"/>	SWOLLEN JOINTS	
<input type="checkbox"/>	FREQUENT COLDS	
<input type="checkbox"/>	FREQ SORE THROAT	
<input type="checkbox"/>	FREQ EAR INFECTION	
<input type="checkbox"/>	TUBERCULOSIS	
<input type="checkbox"/>	TUBES IN EARS	
<input type="checkbox"/>	TUMORS	
<input type="checkbox"/>	URINARY DISORDERS	
<input type="checkbox"/>	3RD MOLAR EXTRACTION	

**7. PLEASE INDICATE ANY EYE, EAR, MOUTH, AND/OR NOSE PROBLEMS**

L=LEFT R=RIGHT B=BOTH SIDES

DETAILS

<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BLURRED VISION	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	DOUBLE VISION	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	EYE PAIN	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	PAIN BEHIND EYES	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	PRESSURE BEHIND EYES	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	SENSITIVITY TO LIGHT	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	TEARING EYES	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BLOODSHOT EYES	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BUZZING IN EARS	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	RINGING IN EARS	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	PAIN IN FRONT OF EARS	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	PAIN BEHIND EARS	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	PAIN IN EARS	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	HEARING LOSS	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	EAR INFECTIONS	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BURNING TONGUE	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BROKEN TEETH	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	CHRONIC SINUSITIS	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	DRY MOUTH	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	CHEEK BITING	

***I CERTIFY THAT THE ABOVE HISTORY IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.***

SIGNED NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_