REVIEW OF PATIENT SYSTEMS

Name_____ Date _____ Age _____

Known Allergies_____

Medications_____

_____

_____

_____

Vitamins/Herbs/Minerals_____

_____

Please CIRCLE the following symptoms that you are currently experiencing.
Please CHECK MARK next to the items you have had previously.

General
Chills
Convulsions/Shaking/Tremors
Dizziness/Vertigo
Fainting
Fatigue
Loss of weight
Numbness
Sweats

Muscle and Joint
Arthritis
Bursitis
Foot trouble
Hernia
Low back pain
Neck pain or stiffness
Pain or numbness in:
Shoulders
Arms
Elbows
Hands
Painful tailbone
Buttocks
Legs
Knees
Feet
Swollen joints

Respiratory
Chest pain
Chronic cough
Difficult breathing
Spitting up phlegm

Gastro-Intestinal
Hemorrhoids
Intestinal Worms/Parasites
Irritable Bowel Syndrome
Jaundice
Nausea
Pain over stomach
Vomiting
Vomiting of blood

Cardio-Vascular
High blood pressure
Low blood pressure
Pain over heart
Poor circulation
Rapid heart beat
Slow heart beat
Swelling of ankles

Skin
Acne
Bruise easily
Dryness
Hives
Itching
Rash
Slow healing/clotting
Varicose veins

Genito-Urinary
Bed-wetting
Blood in urine
Difficult urination
Frequent urination
Kidney infection/stones
Painful urination
Pus in urine

Eyes, Ears, Nose & Throat
Asthma
Difficulty reading
Ear discharge
Eye pain
Farsighted
Hearing loss
Nasal blockage
Nearsighted
Nosebleeds
Sinus infection
Sore throat
Swollen glands
Visual Disturbance

For Women Only
Candida/Yeast
Cramps or backache
Excessive menstrual flow
Hot flashes
Irregular cycle
Menopausal symptoms
Miscarriage
Painful menstruation
Premenstrual syndrome
Polyps
Swollen/painful breasts
Vaginal discharge

Are you pregnant? Y / N
Due date_____

REVIEW OF PATIENT SYSTEMS

Name_____ Date _____ Age _____

Please circle to indicate if you have had any of the following conditions:

AIDS
Alcoholism
Allergy Shots
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Bleeding Disorders
Breast Lump
Bronchitis
Bulimia
Cancer
Cardiac Arrhythmias
Cataracts
Chemical Dependency
Chicken Pox
Cold Sores
Depression
Diabetes
Diphtheria
Eczema
Emphysema
Epilepsy
Glaucoma
Goiter
Gonorrhea
Gout
Heart Disease
Hepatitis
Hernia
Herniated Disk
Herpes
High Cholesterol
Kidney Disease
Liver Disease
Measles
Migraine Headaches
Mononucleosis
Multiple Sclerosis
Mumps
Osteoporosis
Pacemaker
Parkinson's Disease
Pneumonia
Polio
Prostate Problem
Prosthesis
Raynaud's Phenomenon
Rheumatoid Arthritis
Rheumatic Fever
Scarlet Fever
Scoliosis
Severe Emotional Stress
Stroke
Suicide Attempt
Thyroid Problems
Tuberculosis
Tumors, Growths
Typhoid Fever
Ulcers
Vaginal Infections
Venereal Disease
Whooping Cough
Other_____
Other_____

Please describe any: _____ Date(s)_____

Head Injuries_____
Falls_____
Concussion_____
Unconsciousness_____
Broken bones_____
Dislocations_____
Auto accident_____
Hospitalization_____
Surgeries_____
Other_____

Family Health Information

This information about your family members will give us a better picture of your total health

Name Relation Past & Present Health Problems

_____
_____
_____
_____
_____

CRANIAL DENTAL HISTORY

Name_____ Date _____ Age _____

Current Dentist_____ Last dental appointment_____ Last Dental X-rays_____

Please describe any of the following: How many times?___ ___ ___ Date(s)_____

Orthodontics / Braces _____

Dental, cranial or facial surgery_____

Wisdom tooth removed: (circle) _____ upper right upper left lower right lower left_____

Root canals: (How many/Which teeth) _____

Extractions: (How many/Which teeth) _____

Crowns: (How many/Which teeth) _____

Bridges: (How many/Which teeth) _____

Implants: (How many/Which teeth) _____

Please CIRCLE the following symptoms that you are currently experiencing.
Please CHECK MARK next to the items you have had previously.

Splint or night guard	Jaw popping, clicking or locking
Retainer	Vertigo
Oral appliance	Ear pain
History of grinding or clenching	Plugged ears
Tooth pain	Tinnitus or ear noises
Bleeding gums	Headaches
Jaw pain or stiffness	Facial pain

Sleep Quality

Average bedtime_____ Average hours of sleep_____Average wake up time_____

Do you awaken in middle of night? **Y** or **N** (please circle) Approx. what time?_____

Would you describe your sleep as more **restful** or **restless?** (please circle)

Do you take any sleep aids? **Y** or **N**

Have you been diagnosed with sleep apnea? **Y** or **N** When? _____

Date of Sleep Study: _____

Do you snore? **Y** or **N** Does your spouse / partner complain about your snoring? **Y** or **N**

Do you have restless legs in bed? **Y** or **N**

Age of your mattress?_____ Age of your pillow?_____