Houston TMJ
Facial Pain & Sleep

MEDICAL HISTORY QUESTIONNAIRE

Last name: ______________________ First name: _____________ D.O.B ___/___/___

Please check the box for any condition which you have had in the past or have now.

(1) Cardiovascular
[ ] Congestive Heart Failure
[ ] Heart Attack
[ ] Angina Pectoris or Chest Pain
[ ] High Blood Pressure
[ ] Heart Murmur
[ ] Mitral Valve Prolapse
[ ] Rheumatic Fever
[ ] Congenital Heart Defect
[ ] Artificial (Prosthetic) Heart Valve
[ ] Bacterial Endocarditis
[ ] Tetralogy of Fallot
[ ] Arrhythmias
[ ] Heart Pacemaker or Defibrillator
[ ] Coronary By-Pass
[ ] Coronary Angioplasty
[ ] Heart Transplant
[ ] Aneurysm
[ ] Heart Surgery
[ ] High Cholesterol
[ ] Other Heart Problems

(2) Hematologic
[ ] Blood Transfusion
[ ] Anemia
[ ] Von Willebrand's
[ ] Hemophilia
[ ] Leukemia
[ ] Lymphoma
[ ] Sickle Cell Anemia
[ ] Tendency to bleed longer than normal
[ ] Taking blood thinner

(3) Neurologic
[ ] Vision Problems
[ ] Glaucoma
[ ] Ringing in Ears
[ ] Hearing Loss
[ ] Headaches
[ ] Fainting or Dizzy Spells
[ ] Stroke
[ ] Epilepsy, Seizures or Convulsions

(4) Gastrointestinal
[ ] Stomach/Intestinal Ulcers
[ ] Colitis
[ ] Irritable Bowel Syndrome
[ ] Hepatitis
[ ] Liver Disease
[ ] Yellow Jaundice
[ ] Cirrhosis
[ ] Gastric Acid Reflux

(5) Pulmonary
[ ] Hay Fever
[ ] Sinus Trouble
[ ] Allergies or Hives
[ ] Asthma
[ ] Chronic Cough
[ ] Emphysema
[ ] Chronic Bronchitis
[ ] Tuberculosis (TB)
[ ] Other Breathing Difficulties
[ ] Snoring
[ ] Sleep apnea

(6) Dermal / Musculoskeletal
[ ] Allergy to Latex (Rubber)
[ ] Skin Rash
[ ] Dark Mole(s)
[ ] Osteoarthritis
[ ] Rheumatoid Arthritis
[ ] Systemic Lupus
[ ] Artificial (Prosthetic) Joint
[ ] Fibromyalgia
[ ] Chronic Fatigue Syndrome
[ ] Scleroderma
[ ] Sjögren's Syndrome
[ ] CRPS I (RSD)
[ ] CRPS (Causalgia)
[ ] Taking medicine for bone problems (bisphosphonates)

(7) Endocrine
[ ] Diabetes
[ ] Thyroid Disease
[ ] Taking Cortisone or Other Steroids
[ ] Hormone Replacement Therapy

(8) Genitourinary
[ ] Kidney, Bladder Problem
[ ] Dialysis
[ ] Kidney Transplant
[ ] Sexually Transmitted Disease (Syphilis, Gonorrhea, Chlamydia or Genital Herpes)
[ ] HIV Positive / AIDS
[ ] Interstitial Cystitis
[ ] Endometriosis

(9) Other Conditions
[ ] Eating Disorder
[ ] Anxiety Disorder
[ ] Panic Attacks
[ ] Phobias
[ ] Depression
[ ] Post-traumatic stress disorder (PTSD)
[ ] Psychiatric Treatment
[ ] Enlarged Lymph Node or "Gland"
[ ] Taste disturbance
[ ] Use Tobacco
[ ] Use Alcohol
[ ] Use Injectable Drugs
[ ] Drug or Alcohol Addiction (Recovery or Current)
[ ] Tumor or Cancer
[ ] Radiation Therapy
[ ] Chemotherapy
[ ] Disease, Problem or Condition not listed
If yes, list:
____
____

Pharmacy name, address, and phone number: ____

Do you have reactions or allergies to drugs or medications? [ ] Yes [ ] No
____
____
____
Have you had an adverse reaction to dental or general anesthetic? [ ] Yes [ ] No

Have you had any surgical procedures? [ ] Yes [ ] No If so, please list them below:
____
____
____
____
List ALL medications, prescription and non-prescription. Please add name, dose, and frequency. Please include regular doses of aspirin, vitamins, and supplements.
____
____
____
____
____
Do you have an immediate family history of cancer, strokes, or autoimmune conditions (rheumatoid arthritis, lupus erythematosus, multiple sclerosis, Sjogren's syndrome)?
[ ] Yes [ ] No

If YES, please describe family relation and any information regarding the diagnosis:
____
____

Females only [ ] Current pregnancy. Expected due date: ___/___/______
[ ] Taking birth control pills or other hormonal contraceptive

How would you estimate your overall health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Name of Primary Care Physician and phone number:
____

Caffeinate intake: [ ] none [ ] coffee [ ] tea [ ] soda [ ] pills [ ] energy drinks.
Number per day: _____.

Tobacco use: [ ] Never smoked [ ] Current smoker [ ] Quit smoking [ ] Socially
[ ] Cigarettes [ ] Pipe/Cigar [ ] Snuff/chew
Number of Packs/Day___. Number of Years smoked___. If you quit, when did you do so? ______

Do you vape? [ ] Yes [ ] No [ ] Quit. How often? [ ] Daily [ ] Weekly [ ] Occasionally

Alcohol use: [ ] None [ ] Occasional [ ] Daily. How many drinks per week? ____

Recreational drug use: [ ] Yes [ ] No. How often? [ ] Daily [ ] Weekly [ ] Rarely.
Which type(s)? [ ] Marihuana [ ] Cocaine [ ] Amphetamines [ ] Heroin
[ ] Other(s): ______________________

[ ] By checking this box, I acknowledge that I have reviewed ALL questions and sections of this medical history form and responded accordingly. I attest that there are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify Houston TMJ Facial Pain and Sleep if any of the information changes.

_____________________________________ ___________________________
Patient/Guardian signature Date