PATIENT INFORMATION

Patient's Legal Name: _____ DOB: _____

Preferred Name: _____ Pronouns: _____ Sex: _____

If Child, Parent/ Guardian's Name(s): _____

Address: _____ City: _____ ZIP: _____

SSN: _____ Age: _____ Email: _____

Phone: _____

Occupation: _____ Employer: _____

Marital Status: _____ Spouse's Name (if applicable): _____

Spouse's Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Family Dentist: _____ Address: _____

Family Physician: _____ Address: _____

Referred by: _____ Address: _____

FINANCIAL INFORMATION

Account Holder's Name: _____ Relationship: _____

Address: _____ City: _____ ZIP: _____

Insurance Company: _____ Medical or Dental

Insured Person's Name: _____ SSN or ID: _____ DOB: _____

Employer: _____ Group #: _____ Plan #: _____

MEDICAL HISTORY

PHYSICAL HEALTH IS: ☐ GOOD ☐ FAIR ☐ POOR

EMOTIONAL HEALTH IS: ☐ GOOD ☐ FAIR ☐ POOR

Do you have a personal physician?	☐ YES	☐ NO
Are you currently under the care of a physician?	☐ YES	☐ NO
Have you ever been seriously ill?	☐ YES	☐ NO
Have you been hospitalized in the past 5 years?	☐ YES	☐ NO
Have you ever had a major operation?	☐ YES	☐ NO
Has there been any change in your general health in the last year?	☐ YES	☐ NO
Has there been a major weight loss, without dieting, in recent months?	☐ YES	☐ NO
Worried about receiving medical/dental treatment?	☐ YES	☐ NO

Have you now, or in the past, experienced any of the following medical conditions?

- ○ Allergies
- ○ Addiction
- ○ Anemia (low blood cell count)
- ○ Arthritis
- ○ Asthma
- ○ Arteriosclerosis
- ○ Bleeding Problems
- ○ Blood Diseases
- ○ Blood Pressure - high
- ○ Blood Pressure -low
- ○ Blood Transfusions
- ○ Bone Disorder
- ○ Breathing or Lung Disorder
- ○ Cancer
- ○ Chronic pain condition
- ○ Diabetes
- ○ Dizziness
- ○ Drug/substance abuse
- ○ Epilepsy
- ○ Endocrine problems
- ○ Female problems
- ○ Gastrointestinal (GI) problems (ulcers)
- ○ Genitourinary problems
- ○ Heart Disease
- ○ Hearing disorder, ringing ears
- ○ Hepatitis A B C (circle)
- ○ HIV/AIDS/ARC (circle)
- ○ Jaundice
- ○ Kidney Disease
- ○ Latex allergy
- ○ Migraine headaches
- ○ Musculo-skeletal disorder
- ○ Neurological disorder
- ○ Psychiatric disorder
- ○ Rheumatic fever
- ○ Sleep disturbance (snoring, night gasping)
- ○ Stroke
- ○ Venereal Disease
- ○ OTHER

_____
_____
_____
_____
_____

List all medications currently taken by the patient

List all allergies include medicine, food, materials, etc.

Please describe below why you are seeking a consultation with Dr. Maryam

Please mark if you currently have or previously had, any of the following conditions:

- ○ Bleeding gums and/or gum disease
- ○ Crowns on teeth and/or caps
- ○ Chew gum regularly
- ○ Feel that your bite closed
- ○ Feel that there is not enough room for your tongue
- ○ Missing back teeth with no replacement
- ○ Oral Surgery
- ○ Periodontal disease (pyorrhea)
- ○ Sore or painful teeth
- ○ Teeth sensitive to cold and/or hot
- ○ Teeth badly worn
- ○ Teeth have been ground down by a dentist
- ○ Teeth extracted within the past three years
- ○ TMJ (jaw joint) treatment
- ○ Treated for a bad bite
- ○ Wisdom teeth removed
- ○ Have frequent canker sores or cold sores
- ○ None

CRANIOFACIAL PAIN (Please check all that apply)

- ○ Generalized facial pain
- ○ The pain is a dull, aching sensation
- ○ The pain is a stabbing, sharp, severe sensation
- ○ Pain or discomfort disturbs your sleep
- ○ Suffer from chronic headaches
- ○ Suffer from migraine headaches
- ○ Suffer from tension headaches
- ○ Headaches in right or left temple
- ○ Headaches in the back of the head
- ○ At times you notice that the pain or problems are less or gone completely
- ○ Have pain in my teeth upon awakening
- ○ Teeth hurt from clenching or chewing
- ○ Jaw(s) ache when you chew
- ○ Jaw(s) hurts when you open wide or take a big bite
- ○ Have ear pain
- ○ Have pain in front of the ears
- ○ The degree of pain same in morning as evenings
- ○ None

CRANIOFACIAL PAIN – Continued (Please check all that apply)

- ○ Have chronic stiff neck
- ○ Have neck aches (neck pain)
- ○ Have had chronic shoulder or back pain
- ○ Have been treated for pain
- ○ Have had injections or nerve blocks for pain
- ○ Had relief from pain with injections

How often do you take medicine for the relief of pain?

- ○ Never
- ○ Seldom (a few times a year)
- ○ Occasionally (once a month)
- ○ Often (weekly)
- ○ Frequently (daily)

BREATHING PROBLEMS (Please check all that apply)

- ○ Allergies
- ○ Nose feels stuffy even when you don't have a cold
- ○ Nose runs even when you don't have a cold
- ○ Sinus problems
- ○ Mouth breather
- ○ Use oxygen

EAR PROBLEMS (Please check all that apply)

- ○ Ear ache(s) or ear pain
- ○ Hearing loss
- ○ Ringing, hissing, or buzzing sound in ear(s)
- ○ Itchiness in ear(s)
- ○ Stuffiness in ear(s)

EQUILIBRUM PROBLEMS (Please check all that apply)

- ○ Lightheaded or dizzy
- ○ Often feel nauseous
- ○ Vertigo

EYE PROBLEMS (Please check all that apply)

- ○ Pain in, around or behind your eyes
- ○ Blurred vision
- ○ Eye twitching
- ○ Excessive watering/tearing

POSTURE PROBLEMS (Please check all that apply)

- ○ Backaches
- ○ Abnormal curvature of the spine
- ○ Unequal leg lengths
- ○ Problems sitting still for long periods of time
- ○ Long hours at the computer

SLEEP PROBLEMS (Please check all that apply)

- ○ Snoring
- ○ Witnessed pauses in breathing
- ○ Choking & gasping
- ○ Diagnosed with sleep apnea
- ○ Erectile Dysfunction
- ○ Reflux or GERD

JAW SYMPTOMS (TMJ) (Please check all that apply)

- ○ Previous treatment for jaw joint problems
- ○ Difficulty chewing food
- ○ Pain when chewing
- ○ Grinding and/or clenching during the night
- ○ Grinding and/or clenching during the day
- ○ Difficulty opening wide
- ○ Jaw shifts to one side when fully opened
- ○ Lock jaw or unable to open or close
- ○ Pain in jaw joint(s) Right Left Both
- ○ Noisy jaw joint(s) Right Left Both
- ○ Clicking or Popping Right Left Both
- ○ Jaw is tired after eating a big meal
- ○ Numbness of shoulders, arms, hands or fingers
- ○ Pain in your neck and/or shoulders

LIFESTYLE (Please check all that apply)

- ○ Under a lot of stress
- ○ Nail biting, tongue or lips
- ○ Take mood affecting drugs or stimulants
- ○ Exercise regularly
- ○ Usually eat breakfast
- ○ Drink alcohol
- ○ Smoke
- ○ Work more than 40 hours per week

TRAUMA RELATED PROBLEMS (Please check all that apply)

- ○ Accident or trauma to face
- ○ Accident or trauma to jaw
- ○ Accident or trauma to head
- ○ Accident or trauma to neck
- ○ Severe blow to the side of the head or jaw
- ○ Whiplash or neck injury
- ○ Worn a cervical traction neck collar
- ○ Strain or stretching of the jaw while yawning, chewing, or opening the mouth wide
- ○ Fallen within the last two years
- ○ Other

_____
_____
_____
_____

DENTAL HISTORY (Please check all that apply)

- ○ Thumb sucking
- ○ Speech problems
- ○ Loose teeth
- ○ Missing teeth
- ○ Previous orthodontic treatment
- ○ Teeth/tooth trauma
- ○ Allergies to dental anesthetics

FOR WOMEN (Please check all that apply)

- ○ Have children
- ○ History of miscarriages
- ○ Reached menopause
- ○ Taking birth control pills
- ○ Had surgery on any female organs

PAST	PRESENT		NAME OF DOCTOR
☐	☐	ACUPUNCTURIST	_____
☐	☐	ALLERGIST	_____
☐	☐	CARDIOLOGIST	_____
☐	☐	CHIROPRACTOR	_____
☐	☐	DENTIST	_____
☐	☐	EAR, NOSE, & THROAT	_____
☐	☐	PSYCHOLOGIST	_____
☐	☐	PEDIATRICIAN	_____
☐	☐	NEUROLOGIST	_____
☐	☐	TMJ SPECIALIST	_____
☐	☐	PHYSICAL THERAPIST	_____
☐	☐	PAIN SPECIALIST	_____
☐	☐	UROLOGIST	_____

Comments or concerns:

_____

_____

_____

_____

_____

PATIENT/GUARDIAN SIGNATURE _____ DATE: _____

PRINT NAME: _____