RONALD C. PERKINS, DDS MSD

TMJ, HEADACHES & MIGRAINES, SNORING & SLEEP DISORDERS

PATIENT HISTORY

Date _____ Date of Birth _____

Patient's Name _____ Age _____ Sex _____
Last First Initial

Res. Address _____ Phone _____

City _____ State _____ Zip _____

Occupation _____ Soc. Sec. No. _____

Employed by _____ Business Tel. _____ Cell

O.K. to contact at work? Yes ☐ No ☐ E-Mail Address _____

Bus. Address _____ City _____ Zip _____

Do you have medical insurance? Yes ☐ No ☐ Group # _____ Group Name _____

Name of Spouse _____ Soc. Sec. No. _____

Employed by _____ Occupation _____

Bus. Address _____ City _____ Zip _____ Tel. _____

Does your spouse have medical insurance? Yes ☐ No ☐ Group # _____ Group Name _____

Responsible Party _____ Dental Insurance _____

Name of Physician _____ Name of Dentist _____

Referred by _____ Ages of children at home _____

Do you anticipate a move or transfer in the near future? Yes ☐ No ☐

MEDICAL HISTORY

1. Are you in good health? _____ Yes ☐ No ☐
2. At present, are you under medical care? _____ Yes ☐ No ☐
3. What was the purpose of the visit to your physician? _____
4. Have you ever had a severe illness? _____ Yes ☐ No ☐
5. Check those items which you now are or have been treated for:

a. Anemia	Yes ☐	No ☐			
b. Arthritis or joint disease	Yes ☐	No ☐	r. Respiratory disorders	Yes ☐	No ☐
c. Asthma	Yes ☐	No ☐	s. Rheumatic fever	Yes ☐	No ☐
d. Adenoids/Tonsils problems	Yes ☐	No ☐	t. Tuberculosis	Yes ☐	No ☐
e. Allergies	Yes ☐	No ☐	u. Venereal disease	Yes ☐	No ☐
f. Bone disorders	Yes ☐	No ☐	v. Herpes II, Aids, etc.	Yes ☐	No ☐
g. Cancer	Yes ☐	No ☐	w. Prosthetic Implants	Yes ☐	No ☐
h. Dizziness	Yes ☐	No ☐	***Endocrine Problems***		
i. Ear problems	Yes ☐	No ☐	1. Thyroid	Yes ☐	No ☐
j. Epilepsy	Yes ☐	No ☐	2. Diabetes	Yes ☐	No ☐
k. Fainting	Yes ☐	No ☐	3. Other _____		
l. Head and neck pain	Yes ☐	No ☐	***Drug Sensitivities***		
m. Heart disease	Yes ☐	No ☐	1. Novocain	Yes ☐	No ☐
n. Kidney involvement	Yes ☐	No ☐	2. Penicillin	Yes ☐	No ☐
o. Liver disease (hepatitis)	Yes ☐	No ☐	3. Aspirin	Yes ☐	No ☐
p. Nervousness	Yes ☐	No ☐	4. Codeine	Yes ☐	No ☐
q. Prolonged bleeding	Yes ☐	No ☐	5. Other _____		

6. Do you have any diseases we should be aware of? _____ Yes ☐ No ☐
7. List all drugs or medication now being taken: _____
8. Has anyone in your family had diabetes? _____ Yes ☐ No ☐
9. Women: Are you pregnant? _____ Yes ☐ No ☐

continued on back

MEDICAL HISTORY

Are you missing any permanent teeth? _____ Yes ☐ No ☐

Have you ever had:

a. Orthodontic treatment? _____ Yes ☐ No ☐
b. Oral Surgery? _____ Yes ☐ No ☐
c. Periodontal treatment? _____ Yes ☐ No ☐
d. Your teeth ground or the bite adjusted? _____ Yes ☐ No ☐
e. Worn a bite plate or other appliance? _____ Yes ☐ No ☐

Problems of the jaw - Have you ever experienced:

a. Clicking/Popping of the jaw? _____ Yes ☐ No ☐
b. Pain (joint, ear, side of face)? _____ Yes ☐ No ☐
c. Difficulty in opening and closing? _____ Yes ☐ No ☐
d. Headaches (frequency & location)? _____ Yes ☐ No ☐
e. Jaw locked? _____ Yes ☐ No ☐

Habits - Do you:

a. Bite your fingernails? _____ Yes ☐ No ☐
b. Clench or grind your teeth while awake or asleep? _____ Yes ☐ No ☐
c. Bite your lips or checks regularly? _____ Yes ☐ No ☐
d. Hold foreign objects with the teeth (pencils, pipe)? _____ Yes ☐ No ☐
e. Mouth breathe while awake ? _____ Yes ☐ No ☐

When did you first become aware of your problems? _____

_____

How did you first hear about our office? _____

Who first made you aware of a need for treatment? _____

Reason for today's visit _____

I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to the history record, I will so inform this practice. I also authorize Dr. Ronald C. Perkins to perform an oral exam.

_____ _____

Signature Date

This information has been reviewed with the above named individual.

_____ _____ _____

Signature Position Date