TMJ, Facial Pain, Snoring and Sleep Apnea Center
Michael T. Montgomery, D.D.S.

Health History Form

Background Information:

Date: _____

Name: _____

Age: _____

Medical History:

Have you had any of the following problems: (if you answer no to the underlined organ disorder, you do not need to answer the underlying specific problems)

Heart, Stroke or Blood Vessel Problems: yes no

-high blood pressure yes no

-chest pains (angina) yes no

-how often do they occur? _____

-do the chest pains occur at rest? yes no

-has the pain changed character recently? yes no

-how do you treat them? _____

-does the treatment relieve the pain? yes no

-rheumatic heart disease yes no

-heart murmur yes no

-type? _____

-when was the murmur diagnosed? _____

-was the murmur confirmed on subsequent medical examinations? yes no

-have physicians recommended antibiotics prior to dental care? yes no

-weak heart (congestive heart failure) yes no

-can you climb a flight of stairs w/o stopping? yes no

-how many pillows do you sleep with at night? _____

-palpitations (erratic heart beat or dysrhythmia) yes no

-type? _____

-heart attack(s) yes no

-when: _____

-heart surgeries yes no

-bypass surgery yes no

-prosthetic heart valve yes no

-heart transplantation yes no

-stroke(s) yes no

-when: _____

-other heart or blood vessel problems: _____

Kidney Problems: yes no

-Describe: _____

-Are you ungoing dialysis? yes no

-peritoneal or hematologic

-Have you had a kidney transplant? yes no

-when? _____

-cadaveric or allogeneic

Infectious Diseases: yes no

-If yes, which? hepatitis A, hepatitis B, hepatitis C, tuberculosis (TB), HIV postive, AIDS

-other: _____

Breathing Problems: yes no

-If yes, which?: emphysema, asthma, COPD
-other: _____

Endocrine Problems: yes no
-If yes, which?: diabetes, thyroid problems
-other: _____
-If you have diabetes, is it well controlled? yes no
-Do you take insulin? yes no
If yes, what is your insulin regimen? _____

Nerve and Neurological Problems: yes no
-If yes, which?: seizures, cerebral palsy, ADD, MS, alzheimers, Bell's Palsy, Tic Doloreux
-other: _____

Bleeding and Clotting Problems: yes no
-easy bleeding or bruising yes no
-if yes, what is the cause? _____

Muscle and Joint Problems: yes no
-If yes, which?: rheumatoid arthritis ,osteoartritis, lupus, polymyositis, dermatomyositis, fibromyalgia

Mood Disorder: yes no
If yes, which?: depression, stress/anxiety, manic-depression

Cancer: yes no
-type of cancer: _____
-have you been treated with chemotherapy? yes no
-have you been treated with radiation therapy? yes no

Organ Transplantation: yes no
If yes, type of organ transplanted and date: _____
_____

Dry Eyes: yes no

Oral:
-Dry mouth yes no
-Oral ulcers yes no

Insomnia: yes no
If yes, circle which applies: getting to sleep staying asleep

Sleep Apnea: yes no

Have you had any major surgeries? yes no

Please list the major surgeries you have had and their dates:

surgery date
_____
_____
_____
_____
_____

Are you allergic to any medications? yes no

Please list any medications that you are allergic to and describe your reaction:

medication	description of reaction

Please provide the following information on the medications you are taking:

medication	dose	frequency per day	reason for taking

2- Please provide the following information regarding all of your physicians:

physician name	physician specialty	phone number

Signature: _____