WESTERN RESERVE PERIODONTICS
Periodontics and Implant Surgeries

TMJ PATIENT INFORMATION FORM

(The following information is strictly confidential.)

Date _____

Why are you now seeking periodontal treatment? _____

_____

Mr., Mrs., Miss, Ms. _____ Age _____

Birth Date _____ Marital Status _____ Home Phone ( ) _____

Address _____ City _____ ZIP _____

Occupation _____ Employed By _____ Phone ( ) _____

___

Name of Spouse _____ Occupation _____ Employed By _____

Name of Dentist _____ How Long? _____ Phone ( ) _____

Name of Physician _____ How long? _____ Phone ( ) _____

Whom may we thank for referring you? _____

Dental Insurance: ❑Yes ❑No SS No.: _____

In case of emergency please notify _____ Phone ( ) _____

MEDICAL HISTORY

Height _____ Weight _____ How is your general health? _____

Date of last physical _____ Are you under active medical care? _____

If so, for what? _____

Please check the correct response:

(1) Have there been any changes in your general health recently? ..... ❑No ❑Yes
(2) Have you lost or gained an excessive amount of weight recently? ..... ❑No ❑Yes
(3) Have you been seriously ill within the last year? ..... ❑No ❑Yes
(4) Have you had surgery (an operation) within the last year? ..... ❑No ❑Yes
(5) Have you been treated for a growth or tumor? ..... ❑No ❑Yes
(6) Have you ever had excessive bleeding requiring treatment? ..... ❑No ❑Yes
(7) Have you experienced chest pain or shortness of breath going up a flight of stairs? ..... ❑No ❑Yes
(8) Have you noticed an increase in frequency of urination? ..... ❑No ❑Yes
(9) Have you noticed an increase in thirstiness? ..... ❑No ❑Yes
(10) Please check any of the following which you have had: ❑ **NONE OF THE BELOW**

❑Anemia
❑Arthritis
❑Artificial Joint
❑Cancer
❑Chest Pain
❑Heart Attack
❑Heart Disease
❑Heart Surgery
❑Heart Pacemaker
❑Artificial Heart Valve
❑Mitral Valve Prolapse
❑Heart Murmur
❑High Blood Pressure
❑Low Blood Pressure
❑Stroke
❑Diabetes
❑Family History of Diabetes
❑Osteoporosis
❑Steroid/Cortisone treatments
❑Epilepsy/Seizures
❑Asthma/Emphysema
❑Rheumatic Fever
❑Tuberculosis
❑Glaucoma
❑Ulcers
❑Kidney Disorder
❑HIV/AIDS
❑Skin Disease
❑Thyroid Disorder
❑Fainting/Dizziness
❑Hepatitis/Jaundice
❑Liver Disease
❑Venereal Disease (Herpes, Gonorrhea, Syphilis)
❑Other _____

OVER ➔

Web: www.gumdrs.com
E-mail: ask@gumdrs.com
FAX (216) 464-7338

Dr. Sayuri Smith D.M.D., Ph.D.

Practice Limited to Periodontics with Services in Dental Implants

Parkway Medical Building NORTH BLDG.
3609 Park East Dr., Suite 411
Beachwood OH 44122-4309

(216) 464-8985

Please check the correct response:

(12) Have you ever or are you presently undergoing psychiatric care?.....❑No ❑Yes

(13) Have you ever experienced an unusual reaction to dental local anesthesia ("Novocaine")? .....❑No ❑Yes

(14) Are you allergic to any drugs?.....❑No ❑Yes

If yes, please indicate: ❑Penicillin ❑Aspirin ❑Codeine ❑Latex

❑Other_____

(15) Are you presently taking any drugs or medications and have you taken any during the last year?.....❑No ❑Yes

If yes, please list:_____

_____

(16) Do you take aspirin daily? ❑No ❑Yes Do you take nonsteroidal anti-inflammatories (like Advil) daily?..... ❑No ❑Yes

(17) WOMEN Are you pregnant at this time?.....❑No ❑Yes

(18) WOMEN Are you or have you had menopause (change of life)? .....❑No ❑Yes

(19) WOMEN Have you had a hysterectomy or ovariectomy?.....❑No ❑Yes

(20) WOMEN Do you take birth control pills or have you in the past?.....❑No ❑Yes

TMJ HISTORY

(21) Do you have frequent headaches? .....❑No ❑Yes

(22) Does it hurt to open or close? ❑No ❑Yes Where? ❑Right side ❑Left side

(23) Does it hurt to chew? .....❑No ❑Yes

(24) Do you grind your teeth?.....❑No ❑Yes

If yes, when? ❑A.M. ❑P.M.

(25) Do you clench your teeth?.....❑No ❑Yes

(26) Do you feel as if your teeth "fit" properly? .....❑No ❑Yes

(27) Do you have earaches? .....❑No ❑Yes

(28) Do you have a stiff neck?.....❑No ❑Yes

(29) Do you have head and neck muscle soreness?.....❑No ❑Yes

(30) Do you chew gum? .....❑No ❑Yes

(31) Have you had extensive dental care? .....❑No ❑Yes

(32) Have you had any trauma to your jaw?.....❑No ❑Yes

(33) Does your jaw click or pop? .....❑No ❑Yes

(34) Do you have a fullness in your ears?.....❑No ❑Yes

(35) Have you had orthodontic treatment (braces)? .....❑No ❑Yes

(36) Do you have a sinus problem?.....❑No ❑Yes

(37) Are you under excessive stress at home or at your job? .....❑No ❑Yes

(38) Does your jaw get tired easily? .....❑No ❑Yes

(39) How long has it been bothering you? _____

(40) How would you describe your discomfort? _____

_____

(41) When is it worse? ❑A.M. ❑P.M.

(42) When did it start? _____

Is there any additional information which will help us to help you?_____

_____

This medical/dental history is accurate to the best of my knowledge.

Signature_____