THOMAS J MUNGER III, D.D.S., P.C. Patient Name: (side 1)

DENTAL COMPLAINT OR REASON FOR VISIT: _____

DENTAL HISTORY

_____

Date Last X-Rays Last Visit Date Last Cleaning Was Treatment Completed?

Please answer each question. Circle Yes or No where applicable. Example: Are you alive? (Yes) No

1. Have you been treated for gum disease? No Yes By Whom? _____
2. When do you brush your teeth? _____
3. Has your dental care been Regular Irregular Infrequent
4. If you wear dentures, for how long?_____ Are you having problems? Yes No
5. Does dental treatment make you nervous? No Slightly Moderately Extremely
6. Have you experienced, now or ever had, any of the following?
   a. Dry mouth? (e.g., Frequent drinking of water at night.) Yes No
   b. Food catching between your teeth? Yes No
   c. Sensitivity in your mouth due to heat/cold/sweets? Yes No
   (Circle the ones that apply)
   d. Bad taste in your mouth? Yes No
   e. Bleeding gums? Yes No
   f. Cold sores, canker sores or other mouth sores? Yes No
   g. Orthodontic Treatment? Yes No
   h. Adverse reactions to local anesthetics? Yes No
   If so, what _____
   i. Any serious problems with dental treatment? Yes No
   If so, what _____

CHILDREN:

A. Is this the child's first dental visit? Yes No
B. Is the child worried? Yes No
C. Does he/she suck his/her thumb or use a pacifier? Yes No

_____

Additional Comments

SLEEP DISORDER

1. Do you snore when you sleep? Yes No How severe is your snoring? Moderate Wakes me up
2. Do you sometimes wake up more tired than when you went to sleep? Yes No

TEMPOROMANDIBULAR JOINT DYSFUNCTION

1. Do you have a grating, clicking, cracking or popping sounds in either or both jaw joints when you chew? Yes No
2. Do you have sensations of stuffiness, pressure or blockage in your ears? Yes No
   Is there excessive ear wax production? Yes No
3. Do you ever have a ringing, roaring, hissing, or buzzing sounds in your ears? Yes No
4. Do you ever feel dizzy or faint? Yes No
5. Is your jaw painful or locked when you get up in the morning? Yes No
6. Are you ever nauseous for no apparent reason? Yes No
7. Do you fatigue easily or consider yourself chronically fatigued? Yes No
8. Are there imprints of your teeth on the sides of your tongue? Yes No
9. Is it impossible to swallow quickly five times in a row with the last swallow being as easy as the first swallow? Yes No
10. Does your tongue go between your front teeth when you swallow? Yes No
11. Do your fingers sometimes go numb? Yes No
12. Do you have pain or soreness in any of the following areas: jaw joints, upper jaw or teeth, lower jaw or teeth, side of neck, back of head, forehead, behind eyes, temples, tongue or chewing muscles? Yes No
13. Do you ever awaken with a headache? Yes No
14. Have you ever had a whiplash injury? Yes No
15. Have you ever worn a cervical collar or had neck traction? Yes No
16. Have you ever experienced a blow to the chin, face or head? Yes No
17. Does your jaw deviate to the left or right when you open wide? Yes No

MEDICAL HISTORY

1. Are you having pain or discomfort at this time? . . . . . Yes No
   If so, where _____
2. Have you been a patient in the hospital during the last two years? . . . . . Yes No
   If so, where and for what? _____
3. Have you been under the care of a medical doctor during the past two years? . . . . . Yes No
   If so, who and for what? _____
4. Have you taken any medication or drugs during the past two years? . . . . . Yes No
   If so, list _____
5. Has the amount or type of your medication been changed? . . . . . Yes No
   If so, to what? _____
6. Are you allergic (i.e., itching, rash, swelling of hands, feet or eyes, etc.), or made sick by penicillin, aspirin, codeine, or any other drugs or medication? . . . . . Yes No
   If so, list _____
7. Have you ever had chemotherapy or radiation therapy? . . . . . Yes No
8. Have you ever had any excessive bleeding requiring special treatment? . . . . . Yes No
   If so, when and the cause _____
9. Circle any of the following which you have had or have at present:

Dry Eyes	Ulcers	Bruise Easily
Heart Failure	Head Injuries	AIDS
Heart Disease of Attack	Emphysema	Hepatitis A (infectious)
Angina Pectoris	Cough	Hepatitis B (serum)
High Blood Pressure	Tuberculosis (TB)	Liver Disease
Heart Murmur	Asthma	Yellow Jaundice
Rheumatic Fever	Hay Fever	Blood Transfusion
Congenital Heart Lesions	Sinus Trouble	Drug Addiction
Scarlet Fever	Allergies or Hives	Hemophilia
Artificial Heart Valve	Diabetes	Venereal Disease
Heart Pacemaker	Thyroid Disease	Genital Herpes
Heart Surgery	Chemotherapy	Epilepsy or Seizures
Artificial Joint	Cancer, Leukemia	Fainting of Dizzy Spells
Anemia	Arthritis, Rheumatism	Nervousness
Stroke	Cortisone Medicine	Psychiatric Treatment
Frequent Urination	Glaucoma	Sickle Cell Disease
Kidney Trouble	Head Injuries	Other _____
Ulcers	Difficulty Swallowing	None

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? . . . . . Yes No
11. Do your ankles swell during the day? . . . . . Yes No
12. Do you use more than two pillows to sleep? . . . . . Yes No
13. Have you lost or gained more than 10 pounds this past year? . . . . . Yes No
14. Do you ever wake up from sleep short of breath? . . . . . Yes No
15. Are you on a special diet? . . . . . Yes No
    If so, what _____
16. WOMEN: Are you pregnant now? . . . . . Yes No
    Are you practicing birth control? . . . . . Yes No
    Do you anticipate becoming pregnant? . . . . . Yes No
    Do you have any problems associated with you menstrual period? . . . . . Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform Dr. Munger on the next appointment, without fail.

_____ _____

Date Signature of Patient, Parent or Guardian

Year 2

Changes in Health _____

Date _____ Signature _____

Year 3

Changes in Health _____

Date _____ Signature _____