W. Daniel Billington, DMD, MS, FAAOP

Diplomate, American Academy of Orofacial Pain

Practice Limited to TMJ Therapy and Orofacial Pain

Two Executive Park Drive
Albany, NY 12203
(518) 482-2728
(518) 482-7040 Fax

1799 Route 9
Clifton Park, NY 12065
(518) 383-5563
Fax (518) 373-9273

Medical Health Chart

Name _____ *Age* _____ *Date of Birth* _____
Spouse's Name _____
Address _____
Phone _____ *Cell* _____ *Business Phone* _____
Employer _____ *Occupation* _____
Physician _____ *Date of last physical exam* _____
Dentist _____ *Date of last dental exam* _____

**DK – means doesn't know*

PRESENT HEALTH	*Yes*	*No*	*DK*
1. Do you have any pain or discomfort?	___	___	___
2. Do you consider yourself in good health?	___	___	___
3. Are you presently under a physician's care?	___	___	___
4. Are you taking any medicine, drugs, or pills at the present time?	___	___	___
PRESENT ILLNESSES/OPERATIONS			
1. Have you ever had any major operations?	___	___	___
2. Have you ever been seriously ill?	___	___	___
3. Have you ever been hospitalized for any reason?	___	___	___
CARDIOVASCULAR			
1. Has a doctor ever said you had heart trouble?	___	___	___
2. Do you get out of breath easily?	___	___	___
3. Has a doctor ever said your blood pressure was too high or too low?	___	___	___
4. As a child, did you have Rheumatic fever or Rheumatic heart disease?	___	___	___
5. Are you subject to fainting or dizzy spells?	___	___	___
6. Are your ankles often badly swollen?	___	___	___
BLOOD			
1. Have you ever had anemia or "thin blood"?	___	___	___
2. Have you had abnormal bleeding following previous surgery, extraction of teeth, or from a cut?	___	___	___
3. Do you bruise easily?	___	___	___
4. Have you at times had severe nose bleeds?	___	___	___

ENDOCINE

1. Have you or any member of your family had diabetes?	___	___	___
2. Have you ever received treatment for any type of endocrine or glandular disorder?	___	___	___
3. Does your mouth frequently become dry?	___	___	___
4. Have you ever been diagnosed as having an immune disorder?	___	___	___

NERVOUS

1. Do you suffer from frequent headaches?	___	___	___
2. Have you ever had any severe pains of the face or head?	___	___	___
3. Are you under tension?	___	___	___
4. Do you have constant numbness or tingling in any part of your body?	___	___	___
5. Do you consider yourself nervous?	___	___	___
6. Has a physician ever told you that you had epilepsy?	___	___	___
7. Have you ever had a nervous breakdown?	___	___	___

RESPIRATORY

1. Do you suffer from frequent colds, sore throats, or sinusitis?	___	___	___
2. Have you ever had or lived with anyone that has had tuberculosis?	___	___	___
3. Have you had a chest x-ray within the last year?	___	___	___
4. Have you had a persistent cough?	___	___	___
5. Do you breath primarily through your mouth?	___	___	___

G.I. and G.U.

1. Do you have or have you ever had a stomach or intestinal ulcer or any other stomach trouble?	___	___	___
2. Have you ever had jaundice or hepatitis?	___	___	___
3. Have you ever had liver or gall bladder trouble?	___	___	___
4. Do you have kidney or bladder trouble?	___	___	___
5. Are you on any special type of diet?	___	___	___

ALLERGIES

1. Are you sensitive to any particular medicine (Aspirin, Penicillin, Novacain)?	___	___	___
2. Do you have asthma or hay fever?	___	___	___
3. Have you ever had hives or a rash?	___	___	___
4. Do you have any other allergies?	___	___	___

OTHER

1. Have you ever been treated for a skin disease?	___	___	___
2. Are your joints often painful or swollen – do you have arthritis or bursitis?	___	___	___
3. Have you gained or lost much weight recently?	___	___	___
4. Do you smoke?	___	___	___
5. Do you use electronic cigarettes or vaping products?	___	___	___

	Yes	*No*	*DK*
6. Do you have frequent fever blisters, canker sores or cracking of the corners of your mouth?	___	___	___
7. Have you ever had burning of the tongue or mouth?	___	___	___
8. Have you ever received radiation therapy?	___	___	___
9. Has a doctor ever told you that you had a tumor or cancer?	___	___	___
10. Have you ever had general anesthesia?	___	___	___
11. Have you been diagnosed HIV positive?	___	___	___
12. Have you been tested for the AIDS virus?	___	___	___

FEMALES

1. Are you pregnant now?	___	___	___
2. Did you have any problems associated with your pregnancies or deliveries?	___	___	___
3. Have you undergone or are you undergoing menopause; if so, are there any symptoms?	___	___	___

DENTAL

1. Are you experiencing pain from your mouth at this time?	___	___	___
2. Are you aware of a bad taste or odor in your mouth?	___	___	___
3. Have you ever had a severe toothache?	___	___	___
4. Are you bothered by tooth sensitivity? Hot, cold, sweets?	___	___	___
5. Do cavities develop rapidly?	___	___	___
6. Can you chew satisfactorily?	___	___	___
7. Do you chew on both sides of your mouth?	___	___	___
8. Do you have any particular mouth habits? Lip, cheek, or tongue biting, foreign objects between teeth, etc.?	___	___	___
9. Are you conscious of any habit with your tongue?	___	___	___
10. Do you clench or grind your teeth?	___	___	___
11. Do you awaken in the morning with your teeth together, tired jaws, numb feeling in your teeth or pain in your jaw?	___	___	___
12. Do your teeth come together evenly?	___	___	___
13. Are you conscious of sore, loose or shifting teeth?	___	___	___
14. Do you ever have pain opening or closing your mouth?	___	___	___
15. Does your jaw ever go "out of joint"?	___	___	___
16. Does your jaw ever "click"?	___	___	___
17. Did you ever wear braces for straightening your teeth?	___	___	___
18. Have you ever had any teeth removed?	___	___	___

Are there any additional comments you would like to make concerning any recent illness, operations, medications, examinations or your physical or dental health in general?

Signature: _____ *Date* _____