Initial History and Physical Form

Name: _____ Age: _____

Phone Number: (Home): _____ (Work): _____

Address: _____ City: _____ State: _____

Zip Code: _____ Occupation: _____

Primary Physician: _____ Referred by: _____

Write your chief complaints below and indicate the approximate age of onset.

Health Complaints	Age
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Please do not write in boxed area.

History of Present Illness

Past Medical and Dental History

Please complete the following with the approximate age of occurrence:

Surgery	Age	Serious Infections/Diseases	Age

Typical Childhood Vaccinations? Yes ___ No ___

Toxic Profession Past or Present

(Artist, graphic designer, dentist, dental assistant, gas station worker, painter, etc.)

Profession	Age

Injuries/ Accidents with Stitches

Injury/Accident	Age

Injuries/ Accidents without Stitches

Injury/Accident	Age

Long Periods of Prescription Drugs, over the Counter Drugs, Alcohol, or Cigarettes

Drug	Age

Major Psychological Trauma

Trauma	Age

Travel to Foreign Countries, Long Visits

Country	Age

Travel Vaccinations Yes ___ No ___
Treated for Parasites Yes ___ No ___

Pregnancies/Births/Abortions/ IUD's/Birth Control Pills

Pregnancies etc.	Age

Medications Presently Taking

Medication	Age

Allergies

	Age

Dental Intervention

(Root canals and extractions – please try to name and number tooth – refer to following dental chart. Try to remember age of 1st dental silver amalgam filling and when major revisions were made, crowns placed, etc.

	Age

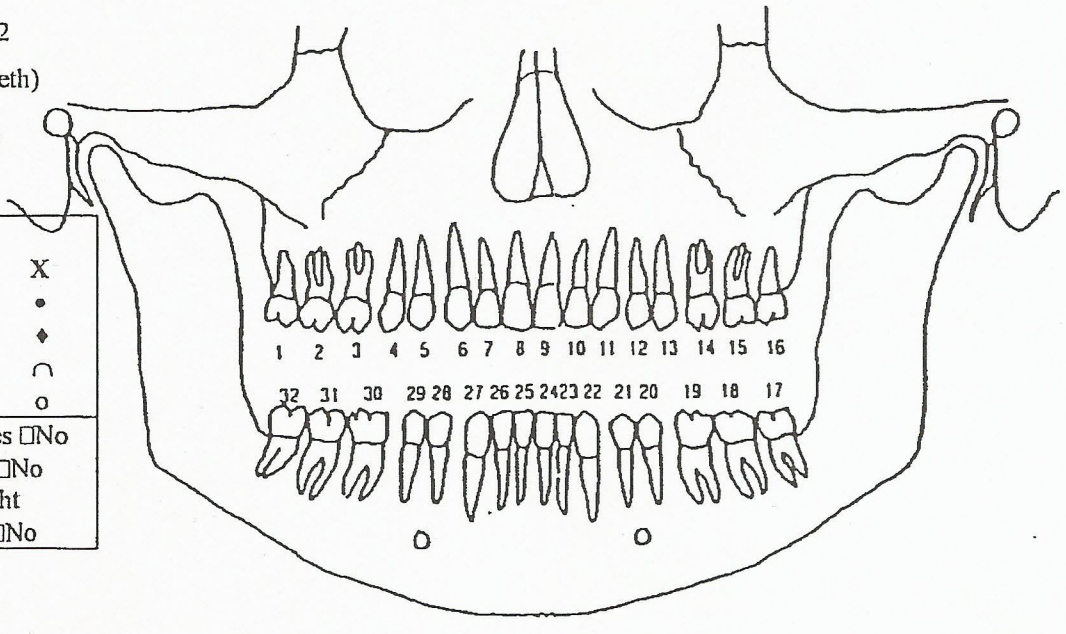
Dental Chart

(Please use the numbered Teeth below to indicate which teeth have had dental intervention. Use the key to appropriately mark on the chart what happened)

Use a Mirror

(#1, 16, 17 & 32 are Wisdom Teeth)

Right Side



Left Side

Key	
Pulled tooth	X
Cavity filled	•
Crown	♦
Bridge	∩
Root canal	o

Dentures? ☐Yes ☐No
Braces? ☐Yes ☐No
Retainer or Night Guard? ☐Yes ☐No

Family Medical History (check all that apply)

☐Asthma ☐Heart Disease ☐Cancer ☐Allergies ☐Stroke

Review of Systems (check all current symptoms)

General

☐Poor appetite ☐Heavy appetite ☐Poor sleep ☐Heavy sleep ☐Insomnia ☐Fatigue ☐Tremors
☐Vertigo ☐Cold hands ☐Cold feet ☐Cold back ☐Cold abdomen ☐Fevers ☐Chills
☐Night sweats ☐Sweat easily ☐Cravings ☐Localized weakness ☐Poor coordination
☐Change in appetite ☐Sudden energy drop at ____(time) ☐Strong thirst (☐cold ☐hot drinks)
☐Bleed or bruise easily (where)_____

Head, Eyes, Ears, Nose, Throat, Mouth

☐Dizziness ☐Concussions ☐Migraines ☐Glasses ☐Eye strain ☐Eye pain ☐Poor vision
☐Night blindness ☐Color blindness ☐Cataracts ☐Blurry vision ☐Earaches ☐Ringing in ears ☐Poor hearing
☐Nose bleeds ☐Sinus problems ☐Mucus ☐Dry throat ☐Dry mouth ☐Copius saliva ☐Teeth problems
☐Jaw clicks ☐Grinding teeth ☐Facial pain ☐Gum problems ☐Spots in eyes ☐Recurrent sore throats ____/month
☐Sore lips or tongue ☐Sensitive teeth ☐Painful Teeth
☐Headaches (where and when) _____
☐Other neck problems _____

Cardiovascular

☐High Blood Pressure ☐Low blood pressure ☐Chest pain ☐Irregular heartbeat
☐Dizziness ☐Fainting ☐Cold hands/feet ☐Swelling in hands/feet ☐Blood clots ☐Phlebitis
☐Difficulty Breathing ☐Other _____

Skin and Hair

☐Rashes ☐Ulcerations ☐Hives ☐Itching ☐Eczema ☐Pimples ☐Dandruff
☐Loss of Hair ☐Change in hair/skin texture ☐Purpura ☐Other hair or skin problems _____

Respiratory

☐Cough ☐Coughing blood ☐Asthma ☐Bronchitis ☐Pneumonia ☐Difficulty in breathing when lying down
☐Tight chest ☐Production of phlegm (what color _____) ☐Other lung problems _____

Gastrointestinal

☐Nausea ☐Vomiting ☐Diarrhea ☐Gas ☐Belching ☐Black stool Bowel movement:
☐Bad breath ☐Rectal pain ☐Hemorrhoids ☐Constipation ☐Bloody stool Frequency_____
☐Sensitive abdomen ☐Pain or cramps ☐Laxative use:___/week; type:___ Color_____
☐Other_____ Odor_____
Texture/form_____

Genito-Urinary

☐Pain on urination ☐Frequent urination ☐Blood in Urine ☐Urgency to urinate
☐Unable to hold urine ☐Kidney stones ☐Venereal disease ☐Impotency
☐Wake up to urinate (how often: ____/night; time: ____) ☐Other G/U problems _____

Musculoskeletal

☐Neck pain ☐Muscle pains ☐Back pain (where_____) ☐Joint pain (where _____)
☐Other joint or bone problems _____

Neuropsychological

☐Seizures ☐Areas of numbness ☐Poor memory ☐Concussion ☐Depression ☐Anxiety
☐Bad temper ☐Easily stressed ☐Treated for emotional problems ☐Considered/attempted suicide
☐Other neurological or psychological problems _____

Thank you for taking the time and effort to complete this form.