PATIENT INFORMATION

Please answer all questions as accurately and thoroughly as possible. The completeness of your answers may directly effect the diagnostic decision made on your behalf. This information will remain confidential.

PATIENT NAME: ____________________________________ ☐M ☐F BIRTHDATE: _______________

IF CHILD, PARENT(S)/GUARDIAN NAME: ____

ADDRESS: _______________________________ CITY: ________________________ ZIP: _____________

HOME PHONE: ________________________ DAYTIME/WORK PHONE: __________________________

SSN #______________________ AGE: _______________ EMAIL: _________________________________

☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED ☐WIDOWED

OCCUPATION: ____________________________ EMPLOYER: __________________________________

IF MARRIED, SPOUSE'S NAME: ____

SPOUSE'S OCCUPATION: ________________________ EMPLOYER: _____________________________

EMERGENCY CONTACT: ________________________________ PHONE: _________________________

FAMILY DENTIST: _______________________ ADDRESS: ____

FAMILY PHYSICIAN: ______________________ ADDRESS: _______________________________________

REFERRED BY: _________________________ ADDRESS: ____

FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR THIS ACCOUNT: ________________________________ RELATIONSHIP: ____________________

ADDRESS: ____

NAME OF INSURANCE CO: ____ MEDICAL OR DENTAL

INSURED PERSON'S NAME: _________________________ SSN OR ID: ____________________ DOB: _______________

EMPLOYER: ___________________________________ GROUP NO.: ___________________ PLAN NO.:________________

Maryam Bakhtiyari, DDS
Diplomate, International Board of Orthodontics
Diplomate, American Board of Craniofacial Pain
Member, American Academy of Dental Sleep Medicine
1117 2ND Street – Manhattan Beach, CA 90266
310-372-6600

MEDICAL HISTORY

PHYSICAL HEALTH IS: ☐ GOOD ☐ FAIR ☐ POOR

EMOTIONAL HEALTH IS: ☐ GOOD ☐ FAIR ☐ POOR

Do you have a personal physician?	☐ YES	☐ NO
Are you currently under the care of a physician?	☐ YES	☐ NO
Have you ever been seriously ill?	☐ YES	☐ NO
Have you been hospitalized in the past 5 years?	☐ YES	☐ NO
Have you ever had a major operation?	☐ YES	☐ NO
Has there been any change in your general health in the last year?	☐ YES	☐ NO
Has there been a major weight loss, without dieting, in recent months?	☐ YES	☐ NO
Worried about receiving medical/dental treatment?	☐ YES	☐ NO

Have you now, or in the past, experienced any of the following medical conditions?

- ○ Allergies
- ○ Addiction
- ○ Anemia (low blood cell count)
- ○ Arthritis
- ○ Asthma
- ○ Arteriosclerosis
- ○ Bleeding Problems
- ○ Blood Diseases
- ○ Blood Pressure - high
- ○ Blood Pressure -low
- ○ Blood Transfusions
- ○ Bone Disorder
- ○ Breathing or Lung Disorder
- ○ Cancer
- ○ Chronic pain condition
- ○ Diabetes
- ○ Dizziness
- ○ Drug/substance abuse
- ○ Epilepsy
- ○ Endocrine problems
- ○ Female problems
- ○ Gastrointestinal (GI) problems (ulcers)
- ○ Genitourinary problems

- ○ Heart Disease
- ○ Hearing disorder, ringing ears
- ○ Hepatitis A B C (circle)
- ○ HIV/AIDS/ARC (circle)
- ○ Jaundice
- ○ Kidney Disease
- ○ Latex allergy
- ○ Migraine headaches
- ○ Musculo-skeletal disorder
- ○ Neurological disorder
- ○ Psychiatric disorder
- ○ Rheumatic fever
- ○ Sleep disturbance (snoring, night gasping)
- ○ Stroke
- ○ Venereal Disease
- ○ OTHER

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List all medications currently taken by the patient

____

List all allergies include medicine, food, materials, etc.

____

Please describe below why you are seeking a consultation with Dr. Maryam

____

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Please mark if you currently have or previously had, any of the following conditions:

- ○ Bleeding gums and/or gum disease
- ○ Crowns on teeth and/or caps
- ○ Chew gum regularly
- ○ Feel that your bite closed
- ○ Feel that there is not enough room for your tongue
- ○ Missing back teeth with no replacement
- ○ Oral Surgery
- ○ Periodontal disease (pyorrhea)
- ○ Sore or painful teeth
- ○ Teeth sensitive to cold and/or hot
- ○ Teeth badly worn
- ○ Teeth have been ground down by a dentist
- ○ Teeth extracted within the past three years
- ○ TMJ (jaw joint) treatment
- ○ Treated for a bad bite
- ○ Wisdom teeth removed
- ○ Have frequent canker sores or cold sores
- ○ None

CRANIOFACIAL PAIN (Please check all that apply)

- ○ Generalized facial pain
- ○ The pain is a dull, aching sensation
- ○ The pain is a stabbing, sharp, severe sensation
- ○ Pain or discomfort disturbs your sleep
- ○ Suffer from chronic headaches
- ○ Suffer from migraine headaches
- ○ Suffer from tension headaches
- ○ Headaches in right or left temple
- ○ Headaches in the back of the head
- ○ At times you notice that the pain or problems are less or gone completely
- ○ Have pain in my teeth upon awakening
- ○ Teeth hurt from clenching or chewing
- ○ Jaw(s) ache when you chew
- ○ Jaw(s) hurts when you open wide or take a big bite
- ○ Have ear pain
- ○ Have pain in front of the ears
- ○ The degree of pain same in morning as evenings
- ○ None

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CRANIOFACIAL PAIN – Continued (Please check all that apply)

- ○ Have chronic stiff neck
- ○ Have neck aches (neck pain)
- ○ Have had chronic shoulder or back pain
- ○ Have been treated for pain
- ○ Have had injections or nerve blocks for pain
- ○ Had relief from pain with injections

How often do you take medicine for the relief of pain?

- ○ Never
- ○ Seldom (a few times a year)
- ○ Occasionally (once a month)
- ○ Often (weekly)
- ○ Frequently (daily)

BREATHING PROBLEMS (Please check all that apply)

- ○ Allergies
- ○ Nose feels stuffy even when you don't have a cold
- ○ Nose runs even when you don't have a cold
- ○ Sinus problems
- ○ Mouth breather
- ○ Use oxygen

EAR PROBLEMS (Please check all that apply)

- ○ Ear ache(s) or ear pain
- ○ Hearing loss
- ○ Ringing, hissing, or buzzing sound in ear(s)
- ○ Itchiness in ear(s)
- ○ Stuffiness in ear(s)

EQUILIBRUM PROBLEMS (Please check all that apply)

- ○ Lightheaded or dizzy
- ○ Often feel nauseous
- ○ Vertigo

EYE PROBLEMS (Please check all that apply)

- ○ Pain in, around or behind your eyes
- ○ Blurred vision
- ○ Eye twitching
- ○ Excessive watering/tearing

POSTURE PROBLEMS (Please check all that apply)

- ○ Backaches
- ○ Abnormal curvature of the spine
- ○ Unequal leg lengths
- ○ Problems sitting still for long periods of time
- ○ Long hours at the computer

SLEEP PROBLEMS (Please check all that apply)

- ○ Snoring
- ○ Witnessed pauses in breathing
- ○ Choking & gasping
- ○ Diagnosed with sleep apnea
- ○ Erectile Dysfunction
- ○ Reflux or GERD

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JAW SYMPTOMS (TMJ) (Please check all that apply)

- ○ Previous treatment for jaw joint problems
- ○ Difficulty chewing food
- ○ Pain when chewing
- ○ Grinding and/or clenching during the night
- ○ Grinding and/or clenching during the day
- ○ Difficulty opening wide
- ○ Jaw shifts to one side when fully opened
- ○ Lock jaw or unable to open or close
- ○ Pain in jaw joint(s) Right Left Both
- ○ Noisy jaw joint(s) Right Left Both
- ○ Clicking or Popping Right Left Both
- ○ Jaw is tired after eating a big meal
- ○ Numbness of shoulders, arms, hands or fingers
- ○ Pain in your neck and/or shoulders

LIFESTYLE (Please check all that apply)

- ○ Under a lot of stress
- ○ Nail biting, tongue or lips
- ○ Take mood affecting drugs or stimulants
- ○ Exercise regularly
- ○ Usually eat breakfast
- ○ Drink alcohol
- ○ Smoke
- ○ Work more than 40 hours per week

TRAUMA RELATED PROBLEMS (Please check all that apply)

- ○ Accident or trauma to face
- ○ Accident or trauma to jaw
- ○ Accident or trauma to head
- ○ Accident or trauma to neck
- ○ Severe blow to the side of the head or jaw
- ○ Whiplash or neck injury
- ○ Worn a cervical traction neck collar
- ○ Strain or stretching of the jaw while yawning, chewing, or opening the mouth wide
- ○ Fallen within the last two years
- ○ Other

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DENTAL HISTORY (Please check all that apply)

- ○ Thumb sucking
- ○ Speech problems
- ○ Loose teeth
- ○ Missing teeth
- ○ Previous orthodontic treatment
- ○ Teeth/tooth trauma
- ○ Allergies to dental anesthetics

FOR WOMEN (Please check all that apply)

- ○ Have children
- ○ History of miscarriages
- ○ Reached menopause
- ○ Taking birth control pills
- ○ Had surgery on any female organs

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PAST	PRESENT		NAME OF DOCTOR
☐	☐	ACUPUNCTURIST	______________________________
☐	☐	ALLERGIST	______________________________
☐	☐	CARDIOLOGIST	______________________________
☐	☐	CHIROPRACTOR	_______________________________
☐	☐	DENTIST	_______________________________
☐	☐	EAR, NOSE, & THROAT	_______________________________
☐	☐	PSYCHOLOGIST	_______________________________
☐	☐	PEDIATRICIAN	_______________________________
☐	☐	NEUROLOGIST	_______________________________
☐	☐	TMJ SPECIALIST	_______________________________
☐	☐	PHYSICAL THERAPIST	_______________________________
☐	☐	PAIN SPECIALIST	_______________________________
☐	☐	UROLOGIST	________________________________

Comments or concerns:

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PATIENT/GUARDIAN SIGNATURE _______________________________________ DATE: ____________

PRINT NAME: ____

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