

TMD/Medical/Dental History

Patient Name:

Date:

Who referred/recommended you to Dr. Padolsky?

What is bothering you the most?

What doctors have you seen about this problem? Please list them all below (include medical)

	Doctor Name	Doctor Type	Dates	Telephone Number	
1					
2					
3					
4					
5					
6					
7					

If you need to add more, write on the back of this form.

Does Dr. Padolsky have your permission to contact previous doctors? Yes No

List all the treatment you have had for this problem.

Signature:

Date: