ALI MAKKI, DMD

Headache and Facial Pain Disorders
41 Creek Road, Suite 340, Irvine, CA 92604-4724
(949) 706-5581 phone ● **(949) 229-6226** fax
ask@headandfacepain.com
headandfacepain.com

HEALTH HISTORY UPDATE

NAME (first):_____ (middle):_____ (last):_____

DATE OF BIRTH: _____ (mm/dd/yyyy) **TODAY'S DATE** _____ (mm/dd/yyyy)

REASON FOR TODAY'S VISIT:

Please mark all that apply: ☐ **Follow-up visit** ☐ **Procedure** ☐ **Complete forms** ☐ **Other**

MEDICATIONS: ☐ **No change since last visit** ☐ **Changes noted below**

*Please list the **name** and **strength** of any prescription and non-prescription medication or supplement (vitamins or herbal remedies) you **currently take**. Also state **how many times a day you take it**.*

Name	**Dose** (mg)	**How many times per day**

(Please use the back of the page to list more medications or attach your own medication list)

ALLERGY: ☐ **No change since last visit** ☐ **Changes noted below**

Please mark all that apply: ☐ **Drug allergy** ☐ **Food allergy** ☐ **Seasonal allergy**

☐ **Other** (additional explanation below)

MEDICAL HISTORY: ☐ **No change since last visit** ☐ **Changes noted below**

Please mark below any condition that applies to you, even if controlled by medication or other means:

☐ **Diabetes** ☐ **Heart disease** ☐ **High blood pressure** ☐ **High cholesterol** ☐ **Kidney disease** ☐ **Liver disease**

☐ T**uberculosis (TB)** active or exposure ☐ Any past or present **infection or exposure to contagious disease**

☐ **Other medical conditions** (additional explanation below)

_____

INJURY / TRAUMA: ☐ **No change since last visit** ☐ **Changes noted below**

Please list below any injury or trauma (physical or emotional) you have sustained (related or unrelated to your current complaint)*, even if it did not require hospitalization or emergency care.* (Please include dates)

_____

HOSPITALIZATION / SURGERY: ☐ **No change since last visit** ☐ **Changes noted below**

Please list below any hospital stay or operations you have had ***recently*** *or* ***in the past****, including dates, reason for hospitalization, type of surgery or procedure, and emergency care (emergency room or urgent care) if any.*

_____

REVIEW OF SYSTEMS: ☐ **No change since last visit** ☐ **Changes noted below**

Please place a check mark if you ***currently*** *have any of the following symptoms:*

1.	**Constitutional:**	____fever	____chills	____night sweats
		____weight loss	____weight gain	____fatigue
		____appetite loss	____appetite gain	____low energy/fatigue
2.	**Eye:**	____blurred vision	____double vision	____loss of vision
		____eye pain	____eye redness	____eye dryness
3.	**Ear/nose/throat:**	____pain in ear(s)	____ringing in ear(s)	____change in hearing
		____dizziness/vertigo	____loss of balance	____ear discharge
		____loss of smell	____nasal drainage	____nasal obstruction
		____hoarseness	____changed speech	____trouble swallowing
4.	**Oral/dental:**	____ongoing toothache	____ongoing gum pain	____pain on chewing
		____change in bite	____burning in mouth/tongue	____change in oral tissues
		____jaw pain	____jaw noise	____jaw locking
		____mouth breathing	____teeth grinding	____jaw clenching
		____involuntary jaw movement	____involuntary tongue movement	
5.	**Cardiovascular:**	____chest pain	____irregular heartbeat	____fast heartbeat
		____fainting	____limb pain on walking	____limb swelling
		____ankle swelling	____blood pressure problem	____vein problem
6.	**Respiratory:**	____trouble breathing	____shortness of breath	____persistent cough
		____coughing up blood	____wheezing	____pain on breathing
		____snoring	____paused breathing in sleep	____daytime sleepiness
7.	**Gastrointestinal:**	____nausea	____vomiting	____abdominal pain
		____heartburn	____indigestion	____regurgitation
		____acid reflux	____constipation	____diarrhea
		____bloody stool	____vomiting blood	____excessive gas
8.	**Genitourinary:**	____unable to hold urine	____pain on urination	____blood in urine
		____frequent urination	____incomplete urination	____irregular menstruation
		____no menstruation	____prostate problem	
9.	**Musculoskeletal:**	____muscle pain	____muscle cramps	____muscle twitching
		____joint pain	____joint stiffness	____loss of muscle bulk
		____joint swelling	____neck pain	____back pain

10. **Skin:**	____rash	____discoloration	____sweating changes
	____hair changes	____nail changes	____swelling
11. **Breasts:**	____lump	____discharge	____enlargement
12. **Neurologic:**	____headache	____face pain	____numbness
	____tingling	____tremors	____clumsiness
	____loss of strength	____paralysis	____trouble concentrating
	____memory problem	____blackouts	____slurred speech
	____light sensitivity	____sound sensitivity	____smell sensitivity
	____phantom smells	____irritability	
13. **Psychiatric:**	____hallucinations	____feeling depressed	____feeling nervous/panic
	____suicidal thoughts	____inappropriate crying	____inappropriate laughing
	____mood swings	____lack of concentration	____trouble with sleep
14. **Endocrine:**	____excessive thirst	____excessive hunger	____excessive urination
	____cold intolerance	____heat intolerance	____thyroid problem
	____abnormal growth of limb	____abnormal breast discharge	
15. **Hematologic/ Lymphatic:**	____abnormal bleeding/clotting	____nosebleeds	____lumps or swellings
16. **Allergic/ Immunologic:**	____skin rash	____joint pain	____dry eyes
	____dry mouth	____non-healing lesion	____frequent infections

Name of person completing this questionnaire: _____

Relationship to patient (self, family, legal representative, interpreter, caregiver, etc.): _____

NOTE: *This questionnaire may be completed by the patient, guardian, authorized relative or representative.* Reference may be made to this information by means of a signed and dated statement for documentation purposes by the treating healthcare provider as a component of clinical encounter notes.

_____

Signature of Patient or Legal Representative **Printed Name** **Date** (mm/dd/yyyy)