Comprehensive Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Referring Physician: _____

Chief Complaints:

Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc…

TMD/PAIN COMPLAINTS

___ Back pain
___ Difficulty swallowing
___ Dizziness
___ Ear congestion
___ Ear pain
___ Eye pain
___ Facial pain
___ Headaches
___ Jaw clicking/Popping
___ Jaw joint noises
___ Jaw locking
___ Jaw pain
___ Limited mouth opening
___ Migraines
___ Morning head pain
___ Muscle twitching
___ Neck pain
___ Nocturnal teeth grinding
___ Pain when chewing
___ Ringing in the ears
___ Throat pain
___ Shoulder pain
___ Sinus congestion
___ Visual disturbances

SLEEP BREATHING COMPLAINTS

___ CPAP intolerance
___ Difficulty falling asleep
___ Fatigue
___ Feeling unrefreshed upon waking
___ Frequent heavy snoring
___ Frequent heavy snoring which affects others
___ Gasping when waking up
___ Morning hoarseness
___ Nighttime choking spells
___ Significant daytime drowsiness
___ Sleepy while driving
___ Swelling in ankles or feet
___ Witnessed apneic events

OTHER (Write in):

_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____

Periodontal Questions:

☐ Do your gums ever bleed?
☐ Have your gums receded, or do your teeth look longer?
☐ Have you ever been told that you have gum problems, including infection or inflammation?
☐ Have you had any adult teeth extracted due to gum disease?
☐ Diet limited to liquid foods
☐ Diet limited to semisolid or soft foods
☐ Difficulty chewing
☐ Difficulty speaking
☐ Difficulty swallowing
☐ Digestive problems
☐ Gagging easily
☐ Mouth sores
☐ Nutritional disorder
☐ Numbness of lower lip
☐ Numbness in jawbone
☐ Tingling in jawbone
☐ Pain in jawbone
☐ Pain when chewing
☐ Pain when swallowing
☐ Poorly fitting dental appliance
☐ Swollen gums
☐ Sore or sensitive gums
☐ Other (please describe)
_____

Symptoms:

HEAD PAIN

L R B **Front of your head (Frontal)**

SEVERITY			**FREQUENCY**			**DURATION**				
Mild	Moderate	Severe	Occasional	Frequent	Constant	Sec	Min	Hrs	Days	Wks

L R B **Entire head (Generalized)**

SEVERITY			**FREQUENCY**			**DURATION**				
Mild	Moderate	Severe	Occasional	Frequent	Constant	Sec	Min	Hrs	Days	Wks

L R B **Top of your head (Parietal)**

SEVERITY			**FREQUENCY**			**DURATION**				
Mild	Moderate	Severe	Occasional	Frequent	Constant	Sec	Min	Hrs	Days	Wks

L R B **Back of your head (Occiptal)**

SEVERITY			**FREQUENCY**			**DURATION**				
Mild	Moderate	Severe	Occasional	Frequent	Constant	Sec	Min	Hrs	Days	Wks

L R B **In your temples (Temporal)**

SEVERITY			**FREQUENCY**			**DURATION**				
Mild	Moderate	Severe	Occasional	Frequent	Constant	Sec	Min	Hrs	Days	Wks

Signature: _____ Date: _____

Symptoms, cont.:

JAW PAIN

L R B Jaw pain – on opening

L R B Jaw pain – while chewing

L R B Jaw pain – at rest

JAW SYMPTOMS

☐ Jaw popping

L R B Jaw clicking

☐ Jaw locks closed

☐ Jaw locks open

☐ Teeth grinding

MOUTH & NOSE RELATED CONDITIONS

☐ Burning tongue

☐ Frequent biting of cheek

☐ Frequent snoring

☐ Broken teeth

☐ Teeth clenching

☐ Dry mouth

EAR RELATED CONDITIONS

☐ Buzzing in the ears

☐ Tinnitus (ringing in the ears)

☐ Ear pain

☐ Ear congestion

☐ Pain in front of the ear

☐ Hearing loss

☐ Recurrent ear infections

☐ Pain behind the ear

EYE RELATED CONDITIONS

☐ Blurred vision

☐ Eye pain

☐ Pain or pressure behind the eyes

THROAT, NECK & BACK RELATED CONDITIONS

☐ Back pain - lower

☐ Back pain - middle

☐ Back pain - upper

☐ Chronic sore throat

☐ Constant feeling of a foreign object in throat

☐ Difficulty in swallowing

☐ Limited movement of neck

☐ Neck pain

☐ Numbness in the hands or fingers

☐ Sciatica

☐ Scoliosis

☐ Shoulder pain

☐ Shoulder stiffness

☐ Swelling in the neck

☐ Swollen glands

☐ Thyroid enlargement

☐ Tightness in the throat

☐ Tingling in the hands or fingers

☐ Chronic sinusitis

☐ Other (please describe)

_____

_____

_____

Pain History:

Which side are the headaches worse?

L R B

Headache spreads to:

☐ Back of head ☐Neck

☐Forehead ☐Temples

☐Back of head and Temples

SEVERITY ON A SCALE OF 0-10

(0=No pain 10=Worst pain imaginable)

___ Jaw pain ___ Neck pain

___ Headaches ___ Facial pain

Signature: _____ Date: _____ _____

Pain History, cont.:

Frequency

☐ Occasional
☐ Frequent
☐ Constant

Duration

☐ Seconds ☐ Days
☐ Minutes ☐ Weeks
☐ Hours

When having pain you report:

☐ Dizziness
☐ Double Vision
☐ Fatigue
☐ Nausea
☐ Sensitivity to light (photophobia)
☐ Sensitivity to noise
☐ Other (please describe) _____

History of Symptoms:

Is there anything that makes your pain or discomfort worse? _____

Is there anything that makes your pain or discomfort better? _____

What other information is important regarding the pain or condition? _____

History of Treatment:

Practitioner's Name	**Specialty**	**Treatment**	**Date**
_____	_____	_____ __	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature _____ Date _____

History of Accident:

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR TRAUMATIC INCIDENT RELATED TO THE CURRENT VISIT:

DATE OF ACCIDENT OR INCIDENT: _____

YOU BELIEVE THE CAUSE OF THE PAIN OR CONDITION TO BE: (SELECT ONE)

☐ A motor vehicle accident
☐ A motorcycle accident
☐ A work related accident
☐ A playground incident
☐ An athletic endeavor
☐ A fight
☐ A fall
☐ An accident
☐ Hit by an object
☐ Hit an object
☐ An Illness
☐ An injury
☐ Orthodontics
☐ Dental procedures
☐ Whiplash
☐ Other (please describe) _____

WERE YOU: (SELECT ONE)

☐ A passenger in a motor vehicle
☐ The driver of a vehicle
☐ A pedestrian
☐ At work
☐ Did you fall?
☐ Were you hit by an object?
☐ Did you hit an object?
☐ Other (please describe) _____

IF IN A VEHICLE, WHERE WAS THE VEHICLE HIT?

☐ At the front end
☐ At the rear end
☐ At the front right area
☐ At the front left area
☐ At the rear right area
☐ At the rear left area
☐ Head on
☐ On driver's side
☐ On passenger's side
☐ Other area (please describe) _____
_____
_____

INDICATE IF THERE WAS ANY TRAUMA:

☐ Forehead
☐ Face
☐ Chin
☐ Side of head
☐ Back of head
☐ Top of head
☐ Teeth
☐ Jaw

Forcibly Struck the:

☐ Steering wheel
☐ Windshield
☐ Passenger's side window
☐ Driver's side window
☐ Passenger's side door
☐ Driver's side door
☐ Headrest
☐ Seat
☐ Roof
☐ Interior of the car

Signature: _____ Date: _____

Draw your pain patterns following this key:

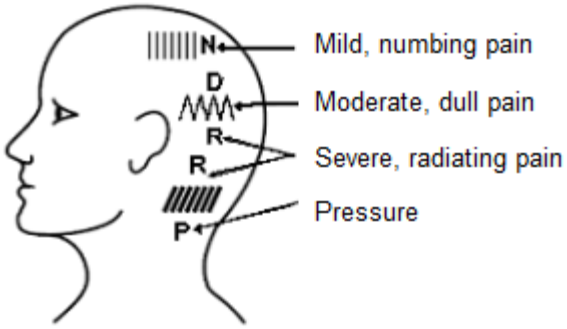
DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

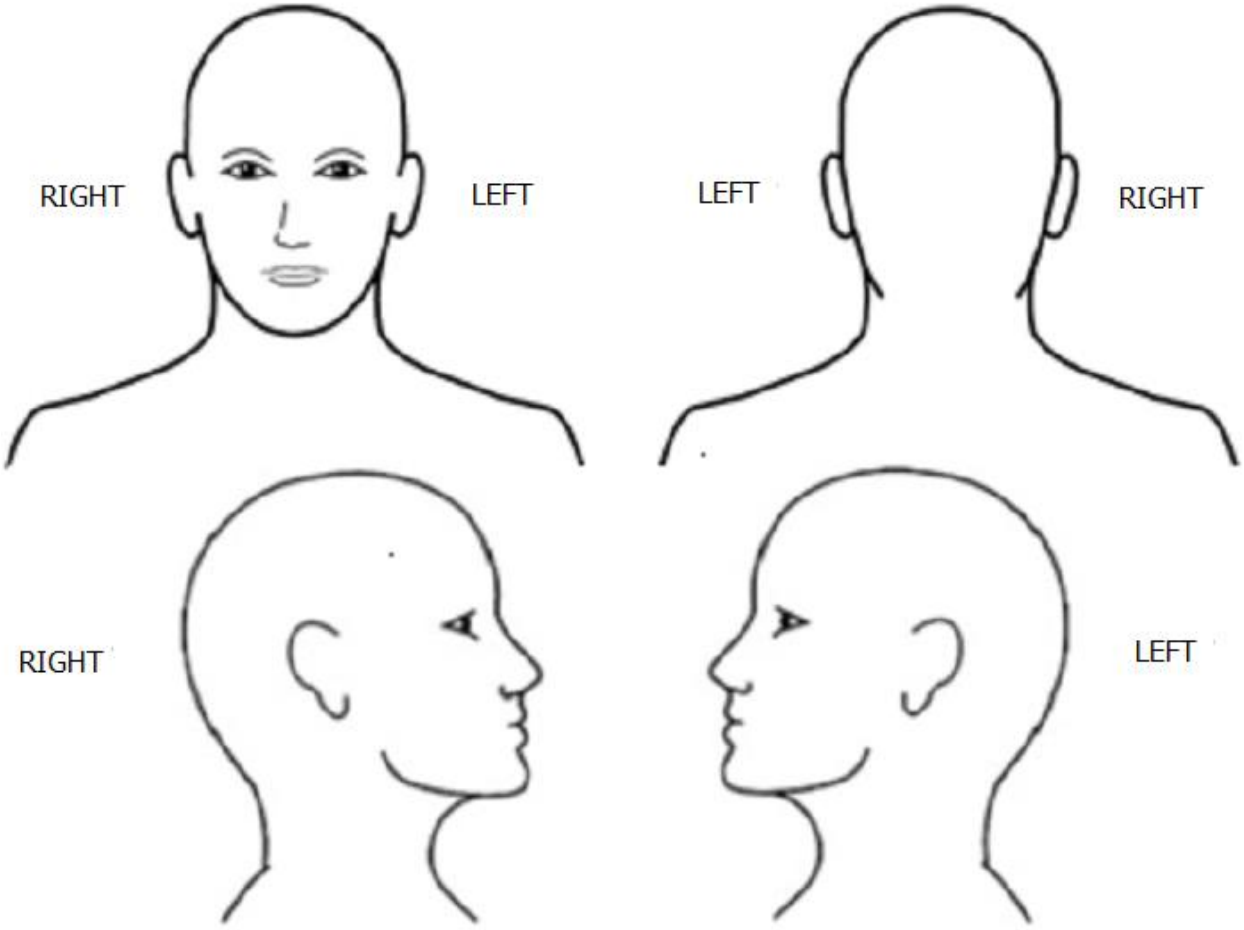
MILD PAIN |||||||

MODERATE PAIN ^^^^

SEVERE PAIN ////////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating





Signature: _____ Date: _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?

No Chance of dozing **0**	**Slight** Chance of dozing **1**	**Moderate** Chance of dozing **2**	**High** Chance of dozing **3**	Sitting and reading
				Sitting and reading
				Watching TV
				Sitting inactive in public place (e.g. a theater or a meeting)
				As a passenger in a car for an hour without a break
				Lying down to rest in the afternoon when circumstances permit
				Sitting and talking to someone
				Sitting quietly after a lunch without alcohol
				In a car, while stopped for a few minutes in traffic

Total Score = _____

Fatigue Scale

During the past week:	**No <**						**>Yes**
	1	**2**	**3**	**4**	**5**	**6**	**7**
I felt fatigued and had less motivation	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and did not desire to exercise	☐	☐	☐	☐	☐	☐	☐
I felt fatigued often	☐	☐	☐	☐	☐	☐	☐
I felt fatigue that interfered with my physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which caused me frequent problems	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which prevented sustained physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and couldn't carry out certain duties & responsibilities	☐	☐	☐	☐	☐	☐	☐
Fatigue was among my three most disabling symptoms	☐	☐	☐	☐	☐	☐	☐
Fatigue interfered with my work, family or social life	☐	☐	☐	☐	☐	☐	☐

Total Score = _____

Signature: _____ Date: _____

Sleep History:

Previous Diagnosis:

Have you been previously diagnosed with Obstructive Sleep Apnea? ☐ Yes ☐ No

If yes, how long ago was it? _____ ☐ Years ☐ Months ☐ Days ago

Are you a current CPAP/BiPAP user? ☐ Yes, current setting is _____ ☐ No

Snoring is reported as:

Frequency	**Severity**
☐ Seldom	☐ Light
☐ Never	☐ Moderate
☐ Daily	☐ Loud
☐ Often	

☐ Worse when sleeping on your back ☐ Worse following alcohol late at night

Sleep:

Sleep Onset Latency ____ minutes

Normally goes to bed at _____ ☐ AM ☐ PM

Hours of sleep per night _____

☐ Bruxism (grinding teeth)

☐ Dry mouth

☐ Excessive movements

☐ Gasping

☐ Restless legs

☐ Waking up and having difficulty returning to sleep

☐ Dreaming

Sleep Aid ☐ Yes ☐ No

If yes, name the medication: _____

# of times per night you get up _____

# of times of nocturnal urination _____

Witnessed apneas are:

☐ Worse when sleeping on your back

☐ Worse following alcohol

Wake:

Sleepiness while driving? ☐ Yes ☐ No

☐ Awakens unrefreshed

☐ Has morning headaches

Naps: ☐ Daily ☐ Never ☐ Occasionally

Sleep Studies:

If you have ever had a Sleep Study, please check on of the following:

☐ Home Sleep Study ☐ Polysomnographic evaluation at a Sleep Disorder Center

Sleep Center Name: _____

Sleep Study Date: _____

Signature: _____ Date: _____

Other Therapy Attempts:

☐ Dieting
☐ Weight loss
☐ Uvuloplasty
☐ Uvulectomy
☐ Pillar procedure
☐ Smoking cessation
☐ CPAP
☐ BiPAP
☐ Uvuloplasty (but continues to have symptoms)
☐ Uvulectomy (but continues to have symptoms)
☐ Positional therapy
☐ Nasal strips

CPAP Intolerance:

If you have attempted treatment with a CPAP device but could not tolerate it, please fill in this section:

☐ Refuses CPAP
☐ Mask leaks
☐ Inability to get the mask to fit properly
☐ Discomfort from headgear
☐ Disturbed or interrupted sleep
☐ Noise disturbing sleep and/or bed partner's sleep
☐ CPAP restricted movements during sleep
☐ CPAP does not seem to be effective
☐ Pressure on the upper lip causing tooth problems
☐ Latex allergy
☐ Claustrophobic associations
☐ An unconscious need to remove the CPAP
☐ Does not resolve symptoms
☐ Noisy
☐ Cumbersome
☐ Other (please describe) _____

Orthodontic Concerns:

☐ Accident
☐ "Buck" or protruding teeth
☐ Crowded teeth
☐ Irregularly shaped teeth
☐ Mismatched bite
☐ Missing tooth
☐ Orthodontic second opinion
☐ Overbite
☐ Overly small mouth
☐ Prominent jaw
☐ Receded jaw
☐ Tooth spacing - excessive

TENDENCIES/HABITS

☐ Clenching
☐ Grinding
☐ Finger sucking
☐ Mouth breathing
☐ Nail biting
☐ Tongue habit
☐ Other (please describe) _____

Past Dental Experiences:

Past experience with dental treatments:

_____

_____

Signature: _____ Date: _____

Expanded Medical History

Allergens:

☐ No Known Allergies	☐ Iodine	☐ Plastic
☐ Antibiotics	☐ Latex	☐ Sedatives
☐ Aspirin	☐ Local Anesthetics	☐ Sleeping Pills
☐ Barbiturates	☐ Metals	☐ Sulfa Drugs
☐ Codeine	☐ Penicillin	☐ _____

Current Medications:

Medicine	Dosage/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History

Medical Condition	Never	Current	Past	Medical Condition	Never	Current	Past
☐ Acid Reflux	☐	☐	☐	☐ Chemotherapy	☐	☐	☐
☐ Anemia	☐	☐	☐	☐ Chronic Fatigue	☐	☐	☐
☐ Atherosclerosis	☐	☐	☐	☐ Chronic Pain	☐	☐	☐
☐ Arthritis	☐	☐	☐	☐ COPD	☐	☐	☐
☐ Asthma	☐	☐	☐	☐ Coronary Heart Disease	☐	☐	☐
☐ Autoimmune Disorder	☐	☐	☐	☐ Current Pregnancy	☐	☐	☐
☐ Bleeding Easily	☐	☐	☐	☐ Depression	☐	☐	☐
☐ Blood Pressure-High	☐	☐	☐	☐ Diabetes	☐	☐	☐
☐ Blood Pressure – Low	☐	☐	☐	☐ Difficulty Sleeping	☐	☐	☐
☐ Bruising Easily	☐	☐	☐	☐ Dizziness	☐	☐	☐
☐ Cancer	☐	☐	☐	☐ Emphysema	☐	☐	☐

Signature: _____ Date: _____

Medical History, cont.:

Medical Condition	Never	Current	Past	Medical Condition	Never	Current	Past
☐ Epilepsy	☐	☐	☐	☐ Mood Disorder	☐	☐	☐
☐ Excessive Daytime Sleepiness	☐	☐	☐	☐ Multiple Sclerosis	☐	☐	☐
				☐ Muscular Dystrophy	☐	☐	☐
☐ Fibromyalgia	☐	☐	☐	☐ Nasal Allergies	☐	☐	☐
☐ Glaucoma	☐	☐	☐	☐ Neuralgia	☐	☐	☐
☐ Gout	☐	☐	☐	☐ Osteoarthritis	☐	☐	☐
☐ Heart Attack	☐	☐	☐	☐ Osteoporosis	☐	☐	☐
☐ Heart Murmur	☐	☐	☐	☐ Parkinson's Disease	☐	☐	☐
☐ Heart Pacemaker	☐	☐	☐	☐ Prior Orthodontic Treament	☐	☐	☐
☐ Heart Valve Replacement	☐	☐	☐				
☐ Hemophilia	☐	☐	☐	☐ Radiation Treatment	☐	☐	☐
☐ Hepatitis	☐	☐	☐	☐ Rheumatic Fever	☐	☐	☐
☐ Hypertension	☐	☐	☐	☐ Rheumatoid Arthritis	☐	☐	☐
☐ Hypoglycemia	☐	☐	☐	☐ Sinus Problems			
☐ Immune System Disorder	☐	☐	☐	☐ Sleep Apnea	☐	☐	☐
☐ Insomnia	☐	☐	☐	☐ Stroke	☐	☐	☐
☐ Ischemic Heart Disease (reduced blood supply)	☐	☐	☐	☐ Tendency for Ear Infections	☐	☐	☐
☐ Kidney Problems	☐	☐	☐	☐ Thyroid Disorder	☐	☐	☐
☐ Liver Disease	☐	☐	☐	☐ Tuberculosis	☐	☐	☐
☐ Meniere's Disease	☐	☐	☐	☐ Tumors	☐	☐	☐
☐ Mitral Valve Prolapse	☐	☐	☐	☐ Urinary Disorders	☐	☐	☐
☐ Recreational Drugs	☐	☐	☐	☐ HIV/AIDS	☐	☐	☐

☐ Other (please describe) _____

Surgical Operations:

☐ Appendectomy	☐ Heart	☐ Thyroid
☐ Back	☐ Hernia Repair	☐ Tonsillectomy
☐ Ear	☐ Lung	☐ Uvulectomy
☐ Gallbladder	☐ Nasal	☐ Periodontal

☐ Other (please describe) _____

Signature: _____ Date: _____

Family History:

Has any member of your family (parent, sibling, grandparent) had:

☐ Cancer	☐ Stroke	☐ Father Snores
☐ Heart Disease	☐ Sleep Disorder	☐ Mother Snores
☐ Diabetes	☐ Obesity	☐ Father has Sleep Apnea
☐ High Blood Pressure	☐ Thyroid Disorder	☐ Mother has Sleep Apnea

Social History:

Occupation: _____ Employer: _____

Tobacco Use:

Cigarettes: ☐ Never Smoked ☐ Current Smoker ☐ Quit

# of packs per day _____ When did you quit? ____

# of years _____ _____

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use:

Do you drink alcohol? ☐ Yes ☐ No If yes, # of drinks per week: _____

Caffeine Intake:

☐ None ☐ Coffee/Tea/Soda # of cups per day: _____

Exercise:

Do you exercise regularly? ☐ Yes ☐ No

Because of HIPPA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner, as required, including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not reimbursed by insurance and that insurance submittal is provided as a courtesy to you. Your dental practitioner may use your health care information and may disclose such information to your insurance company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

I certify that the medical history information is complete and accurate.

Signature: _____ Date: _____

Signature: _____ Date: _____