Facial Problem Questionnaire

Name _____Age_____

Date _____ Referred by _____

Referring Dr.'s Phone # and Email: _____

Please do not write in this space.

Date _____

1. Which of the following do you have (circle all that apply)

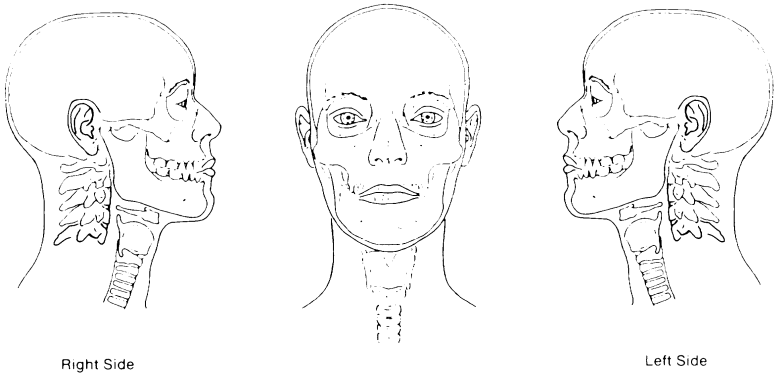
   Headaches Neck Pain Jaw pain Ear Pain

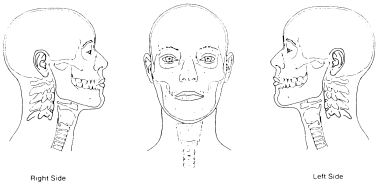
   Facial Pain Bite Problems Damaged teeth Sleep Problem

   Other _____

2. How many days a month are you pain free? _____

   If pain free, go to next page.
   If Pain, Please shade in where your pain is located:





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How long have you had this pain? _____

Is the pain constant? _____

Is the pain (circle all that apply) Aching Burning

Stabbing Sharp Dull Other _____

Is the pain worse in the (circle all that apply)

Morning Afternoon Evening Night

What makes the pain better? _____

_____

What makes the pain worse? _____

_____

How severe is your pain? Please make a mark along the line below:

No Pain ——————————————— Worst Pain Ever

What medication do you take or have you previously taken for your pain?

MEDICATION	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

		Yes		No
3.	Any discomfort when you chew?	Y		N
	Which side do you favor chewing on ?	R	L	Use Both
	Is it difficult or painful to swallow?	Y		N
	Any discomfort when you move your jaw?	Y		N
	Any discomfort upon chewing hard foods like carrots?	Y		N
	Do your jaw muscles get tired from chewing?	Y		N
	Does it hurt to open wide?	Y		N
	Which side of your jaw makes a clicking/popping noise?	R	L	neither
	Which side of your jaw makes other noises?	R	L	neither
	What Noises? _____			
	When did you first notice the noises or clicking? _____			
	Have you noticed any changes in noises or clicking?	Y		N
	Explain: _____			
4.	Have you ever not been able to open your jaw all the way?	Y		N
	Have you ever had to wiggle your jaw to get it open?	Y		N
	Has your jaw ever been stuck open and you could not close it?	Y		N
	When did this first happen? _____ Last happen? _____			
5.	Has your speech changed?	Y		N
	Have you noticed a change in the way your teeth come together?	Y		N
	Have you noticed your teeth shifting?	Y		N
	Has the shape of your face changed?	Y		N
	Has your chin shifted to one side of your face?	Y		N
	When did you notice any of the above changes?_____			
6.	Do you have a hyper-sensitive bite?	Y		N
	Is your bite uncomfortable?	Y		N
	When you close your jaw, do you have to search for a comfortable position for your teeth to fit?	Y		N

Please do not write in this space

Chew
Swallow
Speak
Open/Close

Healthy
Damaged
Active breakdown
Adapting
Adapted

Favorable
Unfavorable

TMJ Move

Structurally Stable

Mech Stable

Occl

7. Are your teeth sore or sensitive? Y N

Do you clench your teeth? Y N

Do you grind your teeth? Y N

Do you grind or clench during the day or night? Day Night Both Neither

When did you start clenching or grinding? _____

Please do not write in this space

Parafunction

8. Do you have a dentist who you see for routine care and cleanings? Y N

Please list : _____ Last Visit: _____

PDHx

Which of the following dental procedures have you had (please circle):

Fillings Orthodontics Root Canal Dentures

Crowns Bridges Bite Adjustment

Ortho

If you had braces, how many times were you in braces? _____

How old were you when you got braces? _____

How old were you when you were done? _____

Have you ever had a tooth extracted? Y N

Have you ever split or broken a tooth? Y N

Do you feel there is any connection between the dental work you have had done and the problems you are having? Y N

Trauma

9. Have you ever injured or sustained any form of trauma or whiplash to your:

(circle all that apply) Jaw Head Neck None of these

(If any past trauma, please complete the trauma questionnaire)

Have you ever had stitches to your chin? Y N

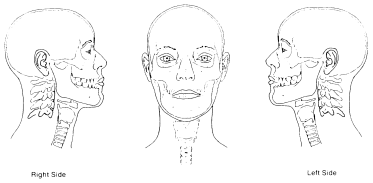
Do you feel there is any connection between the trauma you have had and the problems you are having? Y N

HeadA

10. Do you get headaches? Y N How often? _____

How long do they last? _____

Where does it ache? _____



11. Have you had any changes in your vision? Y N

Do you get visual disturbances along with headaches? Y N

ENT

Do you have problems with your ears? Y N

Dizziness? Y N Ringing? Y N

Hearing? Y N Other? _____

Have you noticed any lumps in your face, throat or neck? Y N

Do you typically breath through your mouth instead of your nose? Y N

Do you have any sinus problems? Y N

Explain: _____

12. Do you have trouble sleeping? Y N

Do you feel rested when you wake up? Y N

How many hours do you sleep? _____

How long does it take you to fall asleep? _____

How many times do you awaken during the night? _____

In which position do you sleep: Back Side Stomach

Do you take any medications to help you sleep? Y N

Please List: _____

Rate your overall daily energy level: Low Less than Before Normal High

Do you snore? Y N

Do you have a sleep partner? Y N

Does your sleep partner snore? Y N

Do you sleep in a different room as your partner? Y N Sometimes

Do you have any trouble breathing during sleep? Y N

Have you ever woken up gasping or choking? Y N

Do you consider yourself under a lot of stress? Y N

Do you worry? Y N

Do you ever get depressed? Y N

How often? _____

Have you ever had a stomach problem? Y N

Ulcers? Y N

Rate the nutrition of your diet: Excellent Good Could be better Poor

Do you use vitamin supplements? Y N

Do you exercise? Y N

Do you currently use (circle): Caffeine Tobacco products Alcohol

Please do not write in this space

Sleep
Airway

Social Hx
Wake to Sleep

Diet
Fitness

13.

Patient Sleepiness Scale (Risk Factors): *Please check all that apply.*	
1. I have been told I stop breathing while asleep	☐
2. I have fallen asleep or nodded off while driving	☐
3. I've woken up with shortness of breath / gasping or my heart racing	☐
4. I feel excessively sleepy or fatigued during the day	☐
5. I snore or have been told that I snore	☐
6. I have had weight gain and found it difficult to lose	☐
7. I have been diagnosed with high blood pressure	☐
8. It takes me less than 10 minutes to fall asleep	☐
9. I wake up more than 1 time per night	☐
10. I wake up with headaches	☐

Patient Health History (Signs & Symptoms): *Please check all that apply.*

- ☐ Snoring
- ☐ Depression/Anxiety
- ☐ Unrefreshed Upon Waking
- ☐ Witnessed Choking/Gasping/Apnea
- ☐ Irritability/Moodiness
- ☐ Wakes Up with Dry Mouth
- ☐ Sinus/Allergy Issues
- ☐ Grind Teeth
- ☐ Diabetes
- ☐ History of Stroke/Heart Disease
- ☐ Acid Reflux/GERD
- ☐ Hypertension
- ☐ Memory Loss
- ☐ Family History of OSA/Snoring
- ☐ Deviated Septum
- ☐ Currently Not Using Prescribed CPAP

Tiredness: How likely are you to dose off in the following situations? Use the following scale to chose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation

Sitting and reading _____
Watching TV _____
Sitting inactive in a public place (e.g. a theater or 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 lunch without alcohol _____
In a car, while stopped for a few minutes in traffic _____

Date of last medical physical: _____ _____
Physician's Name

Have you had a Sleep Test by a Physician? Y N
If yes:
Date: _____

Were you diagnosed with Obstructive Sleep Apnea? Y N

Was CPAP recommended? Y N

CPAP Use (circle all that apply): Every Night Most nights. .Some Nights

When CPAP is used, how many hours is it worn? 2-4 hours 4-6 hours 6-8 hours

Please do not write in this space

14. Do you have or have you had arthritis? Y N

Does anyone related to you have arthritis? Y N

Are your fingers sore or stiff? Y N

Any dry skin patches past or present? Y N

Any skin rashes past or present? Y N

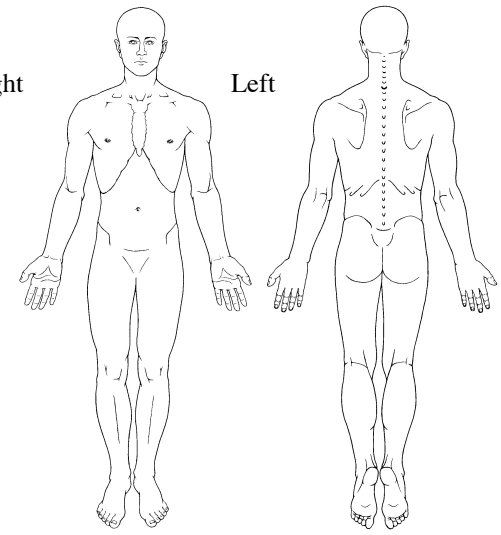
Have you been treated for any other painful condition

in the last three years other than your present problem? Y N

Explain _____

On the diagram below please indicate any other areas that are painful:

Right Left Right



15. Have you had any prior treatment for TMJ problems? Y N

Appliance/Splint? Y N When? _____ Did it help? Y N

Night guard? Y N When? _____ Did it help? Y N

Bite adjustment? Y N When? _____ Did it help? Y N

Orthodontics? Y N When? _____ Did it help? Y N

Other _____

_____

16. Please list, in chronological order, health care providers

you have seen for the problem you are presenting with today:

Date	Doctor or provider	Treatment	Did it help?
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N

Please do not write in this space

Fam Hx

Look for Other

Prior Tx

Please do not write in this space

17. Describe the problem (s) in your own words:

_____

_____

_____

_____

_____

_____

_____

How have these problems affected your life? Does it keep you from doing anything that you want to do? (work, play, chores, eating, talking)

_____

_____

_____

What would you like to accomplish with treatment here?

#1 ii
cc

_____

_____

_____

_____

18. What has Changed and When:

So that I may have a better understanding of your problem, please list in chronological order with date estimates all the changes and/or defining moments of your problem. (Examples are: fell down stairs, left TMJ clicking started, clicking stopped, teeth shifted, headaches increased, headaches stopped, left ear pain.)

Date Estimate	Change that Occurred
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

19. Is there anything else that I should know about?

_____

_____

_____

_____

_____

_____

_____

20. So that I can better understand your pain, please complete the following:

What does your pain feel like? Some of the words below describe your present pain.

Circle all the words that describe it.

Flickering	Jumping	Pricking	Sharp	Pinching
Quivering	Flashing	Boring	Cutting	Pressing
Pulsing	Shooting	Drilling	Lacerating	Gnawing
Throbbing		Stabbing		Cramping
Beating		Lancinating		Crushing
Pounding				
Tugging	Hot	Tingling	Dull	Tender
Pulling	Burning	Itchy	Sore	Taut
Wrenching	Scalding	Smarting	Hurting	Rasping
Searing	Stinging	Aching	Splitting	
			Heavy	
Tiring	Sickening	Fearful	Punishing	Wretched
Exhausting	Suffocating	Frightful	Grueling	Blinding
		Terrifying	Cruel	
		Vicious		
Annoying	Spreading	Tight	Cool	Nagging
Troublesome	Radiating	Numb	Cold	Nauseating
Miserable	Penetrating	Drawn	Freezing	Agonizing
Intense	Piercing	Squeezing		Dreadful
Unbearable		Tearing		Torturing

21. I have completed all 8 pages to the best of my knowledge and I personally have filled in each blank.

_____ _____

signature date