DENTAL MEDICINE PROVIDERS

TMJ/TMD PATIENT QUESTIONNAIRE

Today's date:			MRN:			
PATIENT INFORMATION						
Patient's last name:	First:			Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.
Marital status (circle one) Single / Mar / Div / Sep / Wid	Birth date: / /	Age:	Sex: ❑ M ❑ F		Social Security no.:	
Street address:					Home phone no.: ( )	
City:	State:		ZIP Code:		Cell phone no.: ( )	
Email address:						
Occupation:	Employer:				Work phone no.: ( )	
Employment status:		Last day worked:				
Date of injury:		Claim #:				
Primary treating physician:					Phone no.:	
Adjuster/case manager:					Phone no.:	
Attorney:					Phone no.:	
Other treating physician:					Phone no.:	
Referral source:						
INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Primary insurance: ❑ HMO ❑ PPO ❑ Medicare ❑ Other:						
Subscriber's name:	Subscriber's S.S. no.:		Birth date: / /		Group no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other:		
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address):					Relationship to patient:	
Home phone no.:		Other phone no.:				

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dental Medicine Providers or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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INJURY INFO	
Type of injury:	
Injured body part(s):	
Location of injury:	
Injury event description:	

MEDICATIONS & TREATMENT LIST			
Please list below all **medications** that you are taking for your injury: .			
Medication name	Dose (mg, drops, etc.)	When taken (daily, bedtime, etc.)	Reason for taking (BP, diabetes, etc.)

Please list below any **treatment** you are receiving for your injury:	
1.	2.
3.	4.

TMJ / TMD HISTORY			
YES	NO	Have you ever been diagnosed with TMJ/TMD?	
	If yes, when?		By whom?
YES	NO	Did you have TMJ/TMD treatment before the injury?	
	If yes, describe:		
YES	NO	Have you had TMJ X-rays taken?	
	If yes, when?		By whom?

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PATIENT HISTORY			
YES	NO	Have you been evaluated at a sleep disorders center before?	
YES	NO	Do you have your last meal of the day within two hours of bedtime?	
YES	NO	Do you have a problem with heartburn (GERD) on a regular basis?	
TOBACCO			
YES	NO	Do you smoke tobacco?	
		If YES, how much per day?	How long have you smoked?
YES	NO	If you smoke tobacco, do you smoke when you wake up during the night?	
YES	NO	If you smoke tobacco, have you noticed that nicotine alters or interferes with your sleep?	
BEVERAGES			
YES	NO	Do you usually drink coffee, tea, chocolate, cola or other caffeinated beverages within 3 hours of your bedtime?	
How much of the following do you drink in usual day?			
Coffee/Tea:		Cola:	Chocolate: Other:
YES	NO	Do you drink alcoholic beverages?	
Assuming the following drinks are equivalent-12 oz. beer/5 oz. wine/3 oz. whiskey, gin, or vodka—how many drinks do you have un a usual			
Day:		Weekend:	Holiday:
YES	NO	Do you drink alcohol within two hours of bedtime?	
YES	NO	Do alcoholic beverages alter or interfere with your sleep?	
YES	NO	Have you ever used alcohol in order to get to sleep?	
YES	NO	Have you ever sought treatment/ counseling for an alcohol problem?	

PATIENT EXPECTATIONS

What is the nature of the assistance you expect or desire?

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REVIEW OF SYSTEMS/PAST MEDICAL HISTORY					
(Please fill out completely)					
GENERAL					
YES	NO	Tire easily	YES	NO	Marked weight change
YES	NO	Night sweats	YES	NO	Persistent fever
			YES	NO	Sensitivity to heat or cold
SKIN					
YES	NO	Rashes	YES	NO	Change in hair or nails
EYES / EARS					
YES	NO	Change in vision	YES	NO	Double vision
YES	NO	Change in hearing	YES	NO	Ringing in ears
			YES	NO	Discharge
NOSE					
YES	NO	Change of smell	YES	NO	Obstruction
YES	NO	Excessive discharge	YES	NO	Bleeding
			YES	NO	Sinus infections
MOUTH					
YES	NO	Sore gums or tongue	YES	NO	Lumps or ulcers
THROAT					
YES	NO	Soreness	YES	NO	Hoarseness
HEART AND LUNGS					
YES	NO	Persistent cough	YES	NO	Yellow or green sputum
YES	NO	Bloody sputum	YES	NO	Wheezing
YES	NO	Chest pain/tightness	YES	NO	Difficult breathing lying
YES	NO	Swelling of ankles	YES	NO	High blood pressure
			YES	NO	Palpitations
DIGESTIVE					
YES	NO	Change in appetite	YES	NO	Difficulty swallowing
YES	NO	Heartburn	YES	NO	Abdominal pain
YES	NO	Nausea	YES	NO	Vomiting
YES	NO	Change in stools	YES	NO	Jaundice
ENDOCRINE					
YES	NO	Thyroid trouble	YES	NO	Adrenal trouble
YES	NO	Cortisone treatments	YES	NO	Nursing a baby
GENITOURINARY					
YES	NO	Increased frequency of urination	YES	NO	Nighttime urination
OTHER					
YES	NO	Measles	YES	NO	Mumps
YES	NO	Infectious Mononucleosis	YES	NO	Tuberculosis
YES	NO	Asthma	YES	NO	Rheumatic fever
YES	NO	Kidney disease	YES	NO	Arthritis
YES	NO	High blood pressure	YES	NO	Bleeding tendency
YES	NO	Cancer	YES	NO	Diabetes
YES	NO	Heart Disease	YES	NO	HIV / AIDS

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REVIEW OF SYSTEMS/PAST MEDICAL HISTORY (CONTINUED)					
OPERATIONS					
YES	NO	Tonsillectomy	YES	NO	Appendectomy
YES	NO	Gall Bladder	YES	NO	Nasal
YES	NO	Heart	YES	NO	Thyroid
YES	NO	Ears	YES	NO	Hernia
OTHER:					
ALLERGIES					
YES	NO	Penicillin	YES	NO	Sulfa
YES	NO	Foods	YES	NO	Adverse reaction to anesthesia
OTHER MEDICATION:					
PERSONAL HABITS-DEPENDENCIES					
YES	NO	Caffeine	YES	NO	Alcohol
YES	NO	Tobacco	YES	NO	Non-prescribed drugs
PERSONAL HISTORY					
YES	NO	Could you be pregnant?	YES	NO	Lack of sex drive
LOCOMOTORS					
YES	NO	Muscle cramps	YES	NO	Pain in joints
YES	NO	Swelling in joints	YES	NO	Stiffness
NERVOUS SYSTEM					
YES	NO	Headaches	YES	NO	Dizziness
YES	NO	Fainting	YES	NO	Memory loss
YES	NO	Convulsions	YES	NO	Sleep wellness
YES	NO	Poor cognition	YES	NO	Muscle weakness
			YES	NO	Paralysis
FAMILY HISTORY (Have any blood relatives had any of the follow conditions?)					
YES	NO	Anemia	YES	NO	Bleeding tendency
YES	NO	Leukemia	YES	NO	Repeated infections
YES	NO	Heart disease	YES	NO	Chronic lung disease
YES	NO	Asthma	YES	NO	High blood pressure
YES	NO	Migraine headaches	YES	NO	Diabetes
YES	NO	Cancer	YES	NO	Obesity
YES	NO	Thyroid trouble	YES	NO	Hearing loss
YES	NO	Severe allergies	YES	NO	Mental illness

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MEDICATIONS LIST		
Doctor:	Phone no.:	Fax no.:
Pharmacy	Phone no.:	Fax no.:

Please list below all prescriptions, over-the-counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers and homeopathic remedies.

Medication name	Dose (mg, drops, etc.)	When taken (daily, bedtime, etc.)	Reason for taking (BP, diabetes, etc.)

EVALUATION

Please check the statement that best pertains to you in each of the following categories.

COMMUNICATION

☐	I can talk as much as I want without pain, fatigue, or discomfort.
☐	I can talk as much as I want, but it causes some pain, fatigue or discomfort.
☐	I can't talk as much as I want because of pain, fatigue or discomfort.
☐	I can't talk much at all because of pain, fatigue or discomfort.
☐	Pain prevents me from talking at all.

NORMAL LIVING ACTIVITIES (BRUSHING/FLOSSING)

☐	I am able to care for my gums and teeth in a normal fashion without restrictions, and without pain fatigue or discomfort.
☐	I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/discomfort, jaw tiredness results.
☐	I do manage to care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort, jaw tiredness no matter how careful I am.
☐	I am unable to properly clean all my teeth and gums because of restrictive opening and/or pain.
☐	I am unable to care for most of my teeth and gums because of restricted opening and/or pain.

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NORMAL LIVING ACTIVITIES (EATING/CHEWING)

☐	I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.
☐	I can eat and chew most anything I want, but it sometimes causes pain/discomfort and/or jaw tiredness.
☐	I can't eat much of anything I want, because it often causes pain/discomfort, jaw tiredness or because of restricted opening.
☐	I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue and/or restricted opening.
☐	I must stay on a liquid diet because of pain and/or restricted opening.

SOCIAL/RECREATIONAL ACTIVITIES
(SINGING, PLAYING A MUSCIAL INSTRUMENT, CHEERING, LAUGHING, SPORTS, HOBBIES, ETC.)

☐	I am enjoying a normal social life and/or recreational activities without restriction.
☐	I participate in normal social life and/or recreational activities but pain/discomfort increased.
☐	The presence of pain and/or fear of likely aggravation only limit the more energetic components of my social life (sports, exercise, dancing, playing musical instruments, singing.
☐	I have restrictions socially as I can't even sing, shout, cheer, play, and/or laugh expressively because of increased pain/discomfort.

NON-SPECIALIZED JAW ACTIVITIES (YAWNING, OPENING MOUTH AND OPENING MOUTH WIDE)

☐	I can yawn in a normal fashion, painlessly.
☐	I can yawn and open my mouth fully wide open, but sometimes there is discomfort.
☐	I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.
☐	Yawning and opening my mouth wide are somewhat restricted by pain.
☐	I cannot yawn or open my mouth more than two finger widths (2.8-3.2cm) or, if I can it always causes greater than moderate pain.

SEXUAL FUNCTION
(KISSING, HUGGING, AND ALL SEXUAL ACTIVITIES THAT YOUR ARE ACCUSTOMED TO)

☐	I am able to engage in all my customary sexual activities and expressions without limitation and/or causing headache face or jaw pain.
☐	I am able to engage in all my customary sexual activities and expressions, but it sometimes causes some headache, face or jaw fatigue.
☐	I am able to engage in all my customary sexual activities and expressions, but it usually causes enough headache, face or jaw pain to markedly interfere with my enjoyment willingness and satisfaction.
☐	I must limit my customary sexual activities and expressions because of headache, face or jaw pain or limited mouth opening.
☐	I abstain from almost all sexual activities and expression because of head, face or jaw pain it causes.

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SLEEP	
☐	I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.
☐	I sleep well with the use of pain pills, anti-inflammatory medication or medicinal sleeping aids.
☐	I fail to realize 6 hours of restful sleep even with the use of pills.
☐	I fail to realize 4 hours of restful sleep even with the use of pills.
☐	I fail to realize 2 hours of restful sleep even with the use of pills.
EFFECTS OF TREATMENT (MEDICATIONS, IN-OFFICE THERAPY, TREATMENTS, ICE/HEAT, MOUTHPIECES, SPLINTS, ETC.)	
☐	I do not need to use treatment of any type in order to control or tolerate headache, face or jaw pain and discomfort.
☐	I can completely control my pain with some form of treatment.
☐	I get partial, but significant relief through some form of treatment.
☐	I don't get a lot of relief from any form of treatment.
☐	There is no form of treatment that helps enough to make me want to continue.
TINNITUS (RINGING IN THE EARS)	
☐	I do not experience ringing in my ear(s).
☐	I experience ringing in my ear(s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.
☐	I experience ringing in my ear(s) and it interferes with my sleep and/or daily activities, but I can accomplish set goals and can get an acceptable amount of sleep.
☐	I experience ringing in my ear(s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.
☐	I experience ringing in my ear(s) and it is incapacitating and/or forces me to use a masking device to get any sleep.
DIZZINESS (FEELING LIGHTHEADED, SPINNING AND/OR BALANCE DISTURBANCES)	
☐	I do not experience dizziness.
☐	I experience dizziness but it does not interfere with my daily activities.
☐	I experience dizziness, which interferes somewhat with my daily activities, but I can accomplish my set goals.
☐	I experience dizziness, which causes marked impairment in the performance of my daily activities.
☐	I experience dizziness, which is incapacitating.

The information I have provided is accurate, to the best of my knowledge.

_____ _____

Patient/Guardian signature *Date*