Patient Questionnaire

OFFICE USE
Patient ID: __________

NAME: ____
First *Middle Initial* *Last*

CURRENT DATE: __/__/____

DATE OF BIRTH: __________ ☐MALE ☐FEMALE

Version:
LVICOMBINEDQ

Number
#1 = the most severe symptom

TMD / PAIN COMPLAINTS

- ____ Difficulty Swallowing
- ____ Dizziness
- ____ Facial Pain
- ____ Headaches
- ____ Jaw Clicking
- ____ Jaw Locking
- ____ Jaw Pain
- ____ Limited Mouth Opening
- ____ Migraines
- ____ Morning Head Pain
- ____ Morning Hoarseness
- ____ Neck Pain
- ____ Nocturnal Teeth Grinding

____ ____________________________
____ ____________________________
____ ____________________________

Continued...

- ____ Pain when Chewing
- ____ Ringing in the Ears

SLEEP BREATHING COMPLAINTS

- ____ CPAP Intolerance
- ____ Difficulty Falling Asleep
- ____ Fatigue
- ____ Frequent Heavy Snoring
- ____ Frequent Heavy Snoring Which Affects the Sleep of Others
- ____ Gasping when Waking Up
- ____ Nighttime Choking Spells
- ____ Significant Daytime Drowsiness
- ____ Sleepy while Driving
- ____ Witnessed Apneic Events

____ ____________________________
____ ____________________________
____ ____________________________

Periodontal Questions

- __Yes __No Do your gums ever bleed?
- __Yes __No Have your gums receded, or do your teeth look longer?
- __Yes __No Have you ever been told that you have gum problems, gum infection or gum inflammation?
- __Yes __No Have you had any adult teeth extracted due to gum disease?
- __Yes __No Diet limited to liquid foods
- __Yes __No Diet limited to semisolid or soft foods
- __Yes __No Difficulty chewing
- __Yes __No Difficulty speaking
- __Yes __No Difficulty swallowing
- __Yes __No Digestive problems
- __Yes __No Gagging easily
- __Yes __No Mouth sores

Other

- __Yes __No Nutritional disorder
- __Yes __No Numbness of lower lip
- __Yes __No Numbness in jawbone
- __Yes __No Tingling in jawbone
- __Yes __No Pain in jawbone
- __Yes __No Pain when chewing
- __Yes __No Pain when swallowing
- __Yes __No Poorly fitting upper dental appliance
- __Yes __No Swollen gums
- __Yes __No Sore or sensitive gums

How often do you floss?
(Choose ONE from below)

- ______ weekly
- ______ 2 or 3 times a week
- ______ not at all
- ______ daily

Patient Signature ______________________________ Date ____________________

Symptoms

HEAD PAIN

- __Yes __No Entire head (Generalized)
- [L] [R] [B] Front of your head (Frontal)
- __Yes __No Top of the Head
- [L] [R] [B] Back of your head
- [L] [R] [B] In your temples

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

- [L] [R] [B] Jaw clicking
- __Yes __No Jaw locks closed
- __Yes __No Jaw locks open
- __Yes __No Jaw popping
- __Yes __No Teeth grinding

MOUTH AND NOSE RELATED CONDITION

- __Yes __No Broken teeth
- __Yes __No Teeth clenching
- __Yes __No Dry mouth
- __Yes __No Frequent snoring
- __Yes __No Frequent biting of cheek
- __Yes __No Burning tongue

EAR RELATED CONDITIONS

- __Yes __No Buzzing in the ears
- __Yes __No Tinnitus (ringing in the ears)
- __Yes __No Ear pain
- __Yes __No Ear congestion
- __Yes __No Pain in front of the ear
- __Yes __No Hearing loss
- __Yes __No Recurrent ear infections
- __Yes __No Pain behind the ear

EYE RELATED CONDITIONS

Double Vison, Photophobia in PAIN Hx

- __Yes __No Blurred vision
- __Yes __No Eye pain
- __Yes __No Pain or pressure behind the eyes

THROAT, NECK & BACK RELATED CONDITIONS CONTINUED

- __Yes __No Back pain - lower
- __Yes __No Back pain - middle
- __Yes __No Back pain - upper
- __Yes __No Chronic sore throat
- __Yes __No Constant feeling of a foreign object in throat
- __Yes __No Difficulty in swallowing
- __Yes __No Limited movement of neck
- __Yes __No Neck pain
- __Yes __No Numbness in the hands or fingers
- __Yes __No Sciatica
- __Yes __No Scoliosis
- __Yes __No Shoulder pain
- __Yes __No Shoulder stiffness
- __Yes __No Swelling in the neck
- __Yes __No Swollen glands
- __Yes __No Thyroid enlargement
- __Yes __No Tightness in throat
- __Yes __No Tingling in the hands or fingers
- __Yes __No Chronic sinusitis

Other ____________________ ____________________

Patient Signature ________________________________ Date ____________________

HEAD PAIN HISTORY

Pain Qualities

--- LOCATION ---

______ Which side are the headaches worse?
______ (Choose ONE from below)
______ both sides
the left side
the right side

______ Headache spreads to
______ (Choose ONE from below)
______ the temple
______ the back of the head
______ the temple
the back of the head
the forehead

--- SEVERITY ON A SCALE OF 0-10 ---

--- 0=No Pain 10=Worst Pain Imaginable ---

__________ Jaw Pain on a Numeric Pain Scale

__________ Headaches on a 0-10 Pain Scale

__________ Neck Pain on a Numeric Pain Scale

__________ Facial Pain on a 0-10 Pain Scale

--- FREQUENCY ---

__Yes __No Occasional

__Yes __No Frequent

__Yes __No Constant

--- DURATION ---

__Yes __No Seconds

__Yes __No Minutes

__Yes __No Hours

__Yes __No Days

__Yes __No Weeks

When having pain do you experience:

INDICATE SYMPTOMS IF EXPERIENCED WITH PAIN?

__Yes __No Dizziness

__Yes __No Double vision

__Yes __No Fatigue

__Yes __No Nausea

__Yes __No Sensitivity to light (photophobia)

__Yes __No Sensitivity to noise

__Yes __No Throbbing

__Yes __No Vomiting

__Yes __No Burning

HISTORY OF SYMPTOMS

> When did the pain or condition first occurred
____

______ What do you believe is the cause of the pain or
______ condition
______ (Choose ONE from below)
______ a motor vehicle accident
______ a motorcycle accident
______ a work related incident
______ a playground incident
______ an athletic endeavor
______ a fight
______ a fall
______ an accident
______ an illness
an injury
unknown

> 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?
____

LIST ANY TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:

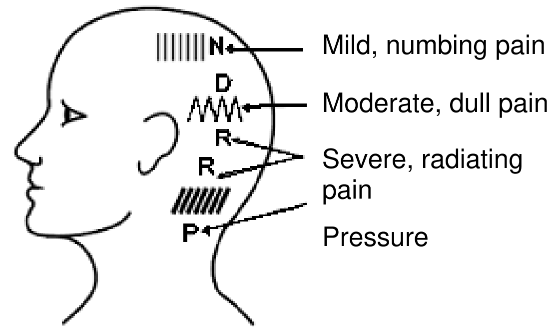
	Practitioner	Specialty	Treatment	(Aprox.) Date
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

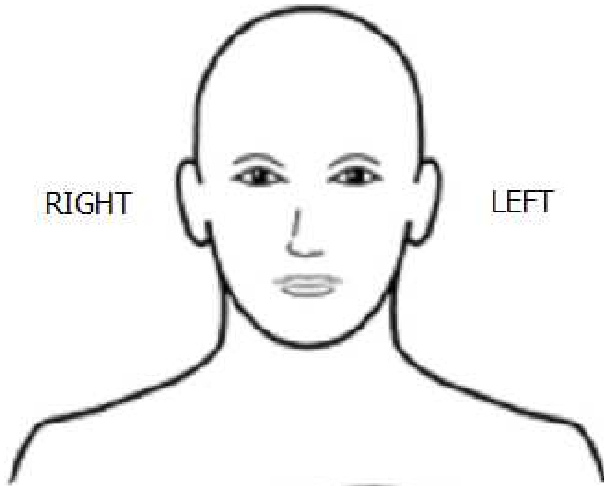
Patient Signature ______________________ Date ______________

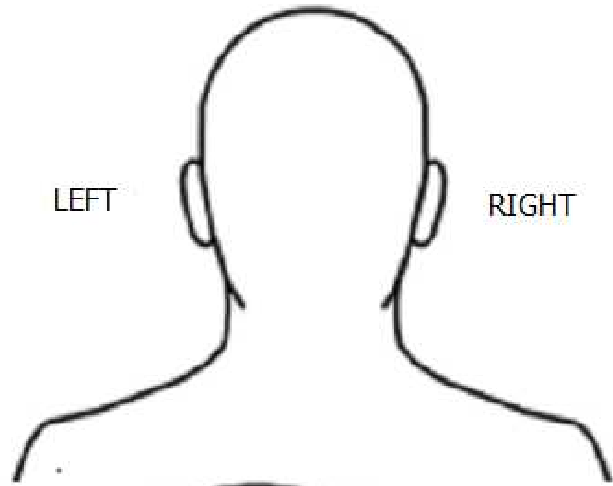
DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

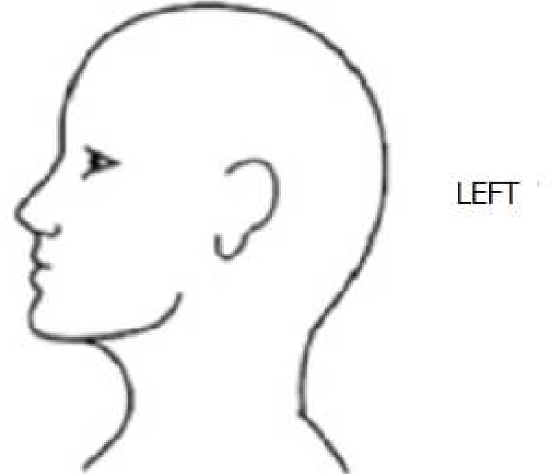
DRAW YOUR PAIN PATTERNS
FOLLOWING THIS KEY:

MILD PAIN	|||||||	**B** Burning
		D Dull
		N Numbing
MODERATE PAIN	ΛΛΛΛ	**P** Pressure
		S Sharp
		T Tingling
SEVERE PAIN	///////	**R** Radiating









Patient Signature ______________________ Date ______________

THE EPWORTH SLEEPINESS SCALE

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

✓ **Check one in each row:**	**0** **No chance of dozing**	**1** **Slight chance of dozing**	**2** **Moderate chance of dozing**	**3** **High chance of dozing**
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (i.e. 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 quitely after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopping for a few minutes in traffic	☐	☐	☐	☐

Total Score: ________ *(Add columns 0-3)*

Patient Signature ______________________ Date ______________

SLEEP HISTORY

Previous Diagnosis

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

If Yes, how long ago was it? ______ ☐ Years ago ☐ Months ago ☐ Days ago
number

Sleep:

Sleep Onset Latency ____ minutes

Normally goes to bed at ____ ☐ AM ☐ PM

Hours of sleep per night ___ hours

Sleep aid ☐ Yes ☐ No

If yes, name that medication _________

__Yes __No Bruxism
__Yes __No Dry mouth
__Yes __No Excessive movements
__Yes __No Gasping
__________ Getting up <number of times> per night
__Yes __No Nightmares
__Yes __No Reading or watching TV before sleeping
__Yes __No Restless legs
__Yes __No Waking up and having difficulty returning to sleep
__Yes __No Dreaming
__________ Frequency of nocturnal urination (# of times)

Witnessed apneas are:

__Yes __No Worse during supine sleep
__Yes __No Worse following alcohol late at night

Wake

Sleepiness while driving ☐ Yes ☐ No

└── Risks discussed ☐ Yes ☐ No

The patient:

__Yes __No Awakens unrefreshed
__Yes __No Has morning headaches
__Yes __No Has problematic daytime sleepiness

______ Naps
______ (Choose ONE from below)
______ naps daily
never napping
occasionally naps

Snoring is reported as:

______ Frequency
______ (Choose ONE from below)
______ seldom
______ never
daily
often

______ Severity
______ (Choose ONE from below)
______ light
moderate
loud

__Yes __No Worse during supine sleep
__Yes __No Worse following alcohol late at night

Patient Signature ______________________________ Date ____________________

FATIGUE SCALE

During the past week:

	No << 1	2	3	4	5	6	>> Yes 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 and responsibilities	☐	☐	☐	☐	☐	☐	☐
Fatigue was among my three most disabling symptoms	☐	☐	☐	☐	☐	☐	☐
Fatigue interfered with my work, family or social life	☐	☐	☐	☐	☐	☐	☐

Total Score: _____

SLEEP STUDIES

Have you ever had an evaluation at a Sleep Center? ☐ Yes ☐ No

☐ Home Sleep Study ☐ Polysomnographic evaluation performed at sleep disorder center

Sleep Center Name ____

Sleep Study Date ____________

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of
☐ mild
☐ moderate obstructive sleep apnea
☐ severe

The evaluation showed

		during REM	*Supine*	*Side*
an RDI of	____	____	____	____
an AHI of	____	____	____	____

a nadir SpO2 of ____ T90 ____

Slow Wave Sleep ☐ Decreased ☐ None
REM Sleep ☐ Decreased ☐ None

Patient Signature ______________________________ Date ____________________

CPAP Intolerance (Continuous Positive Airway Pressure device)

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

__Yes __No Mask leaks
__Yes __No Inability to get the mask to fit properly
__Yes __No Discomfort from headgear
__Yes __No Disturbed or interrupted sleep
__Yes __No Noise disturbing sleep and/or bed partner's sleep
__Yes __No CPAP restricted movements during sleep
__Yes __No CPAP does not seem to be effective
__Yes __No Pressure on the upper lip causing tooth related problems

__Yes __No Latex allergy
__Yes __No Claustrophobic associations
__Yes __No An unconscious need to remove the CPAP
__Yes __No Inability to sleep well
__Yes __No CPAP does not resolve symptoms
__Yes __No Noisy
__Yes __No Cumbersome

Other ____________________ ____________________ ____________________

OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders?

__Yes __No Dieting
__Yes __No Weight loss
__Yes __No Surgery (Uvuloplasty)
__Yes __No Surgery (Uvulectomy)
__Yes __No Pillar procedure

__Yes __No Smoking cessation
__Yes __No CPAP
__Yes __No BiPap
__Yes __No Uvuloplasty (but continues to have symptoms)
__Yes __No Uvulectomy (but continues to have symptoms)

Other

Orthodontic Concerns

REASONS FOR VISIT
__Yes __No Accident
__Yes __No "Buck" or protruding teeth
__Yes __No Crowded teeth
__Yes __No Irregularly shaped teeth
__Yes __No Mismatched bite
__Yes __No Missing tooth
__Yes __No Orthodontic second opinion
__Yes __No Overbite
__Yes __No Overly small mouth

__Yes __No Prominent jaw
__Yes __No Receded jaw
__Yes __No Tooth spacing - excessive

TENDENCIES
__Yes __No Clenching
__Yes __No Grinding
__Yes __No Finger sucking
__Yes __No Mouth Breathing
__Yes __No Nail Biting
__Yes __No Tongue habit

Other

PAST PATIENT EXPERIENCE

__Yes __No My first item
> What are your personal interests for treatment?
____
> Is there anything you would change about the appearance of your teeth?
____

> What are your personal concerns?
____
__________ On as scale of 1-10 how do you feel about keeping your teeth
> What is your timeline for treatment?
____

Other ____
____

Patient Signature ____________________________ Date ____________________

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature ______________________________ Date ______________

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

Patient Signature ______________________________ Date ______________