Patient Health Questionnaire

PATIENT INFORMATION

Date of completion

TMNDX™

☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr.

Name: _____ SSN: _____
First Middle Initial Last

Age: _____ Date of Birth: _____

Referred by: _____ ☐DDS ☐MD ☐ENT ☐DC ☐Other

Location and/or Phone Number of Healthcare Provider: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Contact Number: _____

Type of Employment: _____

Responsible Party (if different than Patient): _____

Address: _____ City: _____ State: _____ Zip: _____

Family Dentist: _____ Address and/or Phone: _____

Family Physician: _____ Address and/or Phone: _____

Reason(s) for this appointment: ☐Pain ☐Sleep/Airway ☐Orthodontics ☐Unknown

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU ARE SEEKING TREATMENT IN OUR OFFICE?

NOTE-PLEASE IDENTIFY YOUR CHIEF COMPLAINT AS #1, LIST ALL OTHER SYMPTOMS IN PRIORITY #2-9.

	Recent	Chronic (6 mo.+)
___ Headache pain	☐	☐
___ Ear pain	☐	☐
___ Jaw pain	☐	☐
___ Pain when chewing	☐	☐
___ Facial pain	☐	☐
___ Eye pain	☐	☐
___ Throat pain	☐	☐
___ Neck pain	☐	☐
___ Shoulder pain	☐	☐
___ Back pain	☐	☐
___ Limited ability to open mouth	☐	☐
___ Jaw joint locking	☐	☐
___ Jaw joint noises	☐	☐
___ Ear congestion	☐	☐
___ Sinus congestion	☐	☐
___ Dizziness	☐	☐
___ Tinnitus (ringing in the ears)	☐	☐
___ Muscle twitching	☐	☐
___ Vision problems	☐	☐
___ Other: _____	☐	☐

	Recent	Chronic (6 mo.+)
___ Kicking or jerking leg repeatedly	☐	☐
___ Swelling in ankles or feet	☐	☐
___ Morning Hoarseness	☐	☐
___ Dry mouth upon waking	☐	☐
___ Fatigue	☐	☐
___ Difficulty falling asleep	☐	☐
___ Tossing and turning frequently	☐	☐
___ Repeated awakening	☐	☐
___ Feeling unrefreshed in the morning	☐	☐
___ Significant daytime drowsiness	☐	☐
___ Frequent heavy snoring	☐	☐
___ Affects sleep of others	☐	☐
___ Gasping when waking	☐	☐
___ Told that "I stop breathing" during sleep	☐	☐
___ Night-time choking spells	☐	☐
___ Unable to tolerate C-Pap	☐	☐
___ Tooth grinding	☐	☐
___ Teeth crowding	☐	☐

Do you have concerns in any of these areas: ☐ General Appearance ☐ Ability to Function ☐ Overbite ☐ Smile

Other Comments: _____

Do any of the above complaints or concerns affect your daily life? _____

WHAT ARE THE RESULTS YOU ARE SEEKING FROM TREATMENT?

_____

Patient Signature: _____ Date: _____

ALLERGIC REACTIONS

Please check any and all medications or substances that have caused an allergic reaction

- ☐ Anesthetics
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Barbituates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Plastic
- ☐ Sedatives
- ☐ Sulfa

Other: _____

CURRENT MEDICATIONS

Please list all medications you are taking and the reason you take them. Include all over-the-counter medications, vitamins, herbs, etc.

Medication	Dosage	Reason for Taking

☐ See attached list

PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

Treatment and/or Medication	Doctor/Provider Name	Approximate Date of Treatment

I release and give my permission for this office to request information and communicate with the providers listed above.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient is a minor): _____ Date: _____

HEALTH AND MEDICAL HISTORY

☐ Yes ☐ No Are you currently pregnant?

☐ Yes ☐ No Have you sustained injury to: ☐ Head ☐ Neck ☐ Face ☐ Teeth ☐ Other: _____

☐ Yes ☐ No Do you drink 4 or more cups of coffee per day? ☐ Yes ☐ No Do you smoke tobacco?

☐ Yes ☐ No Have you had prior orthodontic treatments? ☐ Yes ☐ No Consume alcohol or take sedatives

☐ Yes ☐ No Trouble breathing through nose

Patient Signature: _____ **Date:** _____

HEALTH AND MEDICAL HISTORY (CONTINUED)

Do you have, or have you experienced any of the following:

- ☐ Yes ☐ No Heart Disorder/ Heart Attack
- ☐ Yes ☐ No Heart Murmur
- ☐ Yes ☐ No Mitral Valve Prolapse
- ☐ Yes ☐ No Heart Pacemaker
- ☐ Yes ☐ No Heart Palpitations
- ☐ Yes ☐ No Heart Valve Replacement
- ☐ Yes ☐ No Irregular Heartbeat
- ☐ Yes ☐ No Blood Pressure ☐ High ☐ Low
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Bleeding Easily
- ☐ Yes ☐ No Bruising Easily
- ☐ Yes ☐ No Cancer of _____
  Chemo ☐ Radiation ☐
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No Birth Defects
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Epilepsy
- ☐ Yes ☐ No Emphysema
- ☐ Yes ☐ No Glaucoma
- ☐ Yes ☐ No Gastroesophageal Reflux (Gerd)
- ☐ Yes ☐ No Hemophilia
- ☐ Yes ☐ No Hepatitis
- ☐ Yes ☐ No History of Substance Abuse
- ☐ Yes ☐ No Hypoglycemia
- ☐ Yes ☐ No Huntington's Disease
- ☐ Yes ☐ No Kidney Disease
- ☐ Yes ☐ No Liver Disease
- ☐ Yes ☐ No Leukemia
- ☐ Yes ☐ No Migraines
- ☐ Yes ☐ No Meniere's Disease
- ☐ Yes ☐ No Multiple Sclerosis
- ☐ Yes ☐ No Muscular Dystrophy
- ☐ Yes ☐ No Neuralgia
- ☐ Yes ☐ No Osteoarthritis
- ☐ Yes ☐ No Osteoporosis
- ☐ Yes ☐ No Ovarian Cyst
- ☐ Yes ☐ No Parkinson's Disease
- ☐ Yes ☐ No Rheumatic Fever
- ☐ Yes ☐ No Rheumatoid Arthritis
- ☐ Yes ☐ No Scarlet Fever
- ☐ Yes ☐ No Thyroid Problem
- ☐ Yes ☐ No Tuberculosis
- ☐ Yes ☐ No Intestinal Disorder
- ☐ Yes ☐ No Nervous System Disorder
- ☐ Yes ☐ No Anxiety
- ☐ Yes ☐ No Skin Disorder
- ☐ Yes ☐ No Urinary Tract Disorder
- ☐ Yes ☐ No Chronic Fatigue
- ☐ Yes ☐ No Fibromyalgia
- ☐ Yes ☐ No Cold hands and feet
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Difficulty concentrating
- ☐ Yes ☐ No Difficulty breathing at night for sleep
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Excessive Thirst
- ☐ Yes ☐ No Fainting
- ☐ Yes ☐ No Fluid Retention
- ☐ Yes ☐ No Frequent colds/flu
- ☐ Yes ☐ No Frequent cough
- ☐ Yes ☐ No Frequent ear infections
- ☐ Yes ☐ No Frequent sore throat
- ☐ Yes ☐ No Frequent awaking at night - number of times _____
- ☐ Yes ☐ No Hearing impairment
- ☐ Yes ☐ No Memory Loss
- ☐ Yes ☐ No Hay Fever
- ☐ Yes ☐ No Insomnia
- ☐ Yes ☐ No Muscle aches
- ☐ Yes ☐ No Muscle fatigue
- ☐ Yes ☐ No Muscle spasms
- ☐ Yes ☐ No Muscle tremors
- ☐ Yes ☐ No Poor circulation
- ☐ Yes ☐ No Psychiatric Care
- ☐ Yes ☐ No Recent weight gain
- ☐ Yes ☐ No Recent weight loss
- ☐ Yes ☐ No Sinus problems
- ☐ Yes ☐ No Shortness of breath
- ☐ Yes ☐ No Slow healing sores
- ☐ Yes ☐ No Speech difficulties
- ☐ Yes ☐ No Swollen, stiff or painful joints
- ☐ Yes ☐ No Tired muscles

Additional Information _____

_____

SURGICAL HISTORY *Have you had any of the following:*

- ☐ Yes ☐ No General Anesthesia
- ☐ Yes ☐ No Adenoids removed
- ☐ Yes ☐ No Tonsils removed
- ☐ Yes ☐ No Jaw Joint Surgery
- ☐ Yes ☐ No Orthognathic Surgery
- ☐ Yes ☐ No Oral Surgery

Removal of third molar (wisdom teeth) ☐ Other ☐

☐ Yes ☐ No Other surgery _____ *please list below*

Other types of surgery _____

_____

_____

_____

Patient Signature: _____ Date: _____

CURRENT SYMPTOMS

Head Pain

Location (L=Left R=Right B=Bilateral)	*Recent*	*Chronic* (over 6 mo.)	*Severity* Mild	Mod	Severe	*Duration* Min.	Hrs.	Days	*Frequency* Occasional	Frequent	Constant
L R B Frontal (Forehead)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Generalized	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Parietal (Top of head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Occipital (Back of head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Temporal (Temple area)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you have pain or discomfort in any of the following areas? If so, please indicate the approximate date the pain began.

Jaw Pain

☐L ☐R Jaw pain with opening
☐L ☐R Jaw pain when chewing
☐L ☐R Jaw pain at rest

Jaw Joint Sounds

☐L ☐R Jaw sounds with opening
☐L ☐R Jaw sounds when chewing
☐L ☐R Jaw sounds at rest

Jaw Locking

☐Yes ☐No Jaw locks closed
☐Yes ☐No Jaw locks open

Jaw Joint Symptoms

☐Yes ☐No Teeth clenching ☐Day ☐Night
☐Yes ☐No Teeth grinding ☐Day ☐Night

Eye Related Conditions

☐Yes ☐No Blurred vision
☐Yes ☐No Double vision
☐Yes ☐No Eye pain

☐Yes ☐No Pain or pressure behind the eyes
☐Yes ☐No Extreme sensitivity to light (photophobia)
☐Yes ☐No Wear of glasses or contact lenses

Ear Related Conditions

☐L ☐R Buzzing in the ears
☐L ☐R Ear congestion
☐L ☐R Ear pain
☐L ☐R Hearing loss
☐L ☐R Itchiness or Stuffiness in ears

☐L ☐R Pain behind the ear
☐L ☐R Pain in front of the ear
☐L ☐R Recurrent ear infections
☐L ☐R Ringing in the ear (Tinnitus)

Throat Related Conditions

☐Yes ☐No Chronic sore throat
☐Yes ☐No Difficulty swallowing
☐Yes ☐No Swollen glands

☐Yes ☐No Thyroid enlargement
☐Yes ☐No Tightness in throat
☐Yes ☐No Constant feeling of a foreign object in throat

Neck Related Conditions

☐Yes ☐No Limited movement of neck
☐Yes ☐No Neck pain

☐Yes ☐No Numbness in hands or fingers
☐Yes ☐No Swelling in the neck

Patient Signature: _____ Date: _____

Shoulder Related Conditions

☐ Yes ☐ No Shoulder pain
☐ Yes ☐ No Shoulder stiffness
☐ Yes ☐ No Tingling in hands or fingers

Back Related Conditions

☐ Yes ☐ No Back pain - lower
☐ Yes ☐ No Back pain - middle
☐ Yes ☐ No Back pain - upper
☐ Yes ☐ No Sciatica
☐ Yes ☐ No Scoliosis

Mouth and Nose Related Conditions

☐ Yes ☐ No Dry mouth
☐ Yes ☐ No Chronic sinusitis
☐ Yes ☐ No Frequent snoring
☐ Yes ☐ No Burning tongue
☐ Yes ☐ No Broken teeth
☐ Yes ☐ No Frequent biting of the cheek

Sleep Conditions

Please select Yes or No answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Positions ☐ Side ☐ Back ☐ Stomach ☐ Varies
Is it easy to fall asleep? ☐ Yes ☐ No
Do you feel rested upon AM waking? ☐ Yes ☐ No
Stopped breathing during sleep? ☐ Yes ☐ No

Average hours of sleep per night? _____
Do you wake often during the night? ☐ Yes ☐ No
Gasping or Choking during sleep? ☐ Yes ☐ No
Have you ever had a Sleep Study (PSG)? ☐ Yes ☐ No
Result was _____

HISTORY OF SYMPTOMS

On what date, or approximate date, did this condition or symptoms first occur? _____

☐ Yes ☐ No **Does any family member have the same or similar problem? If yes, please explain.** _____

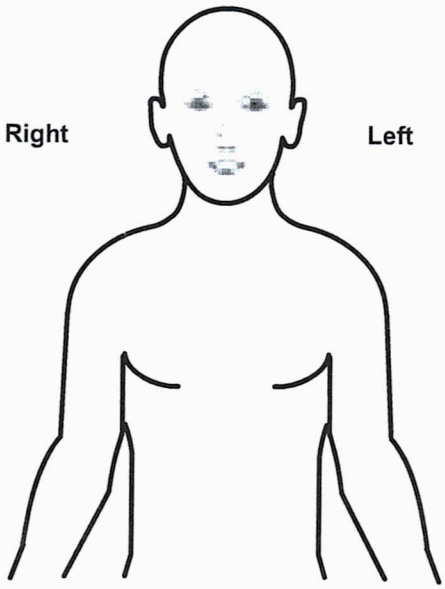
Can you relate your pain or condition to a motor vehicle accident or traumatic injury? _____

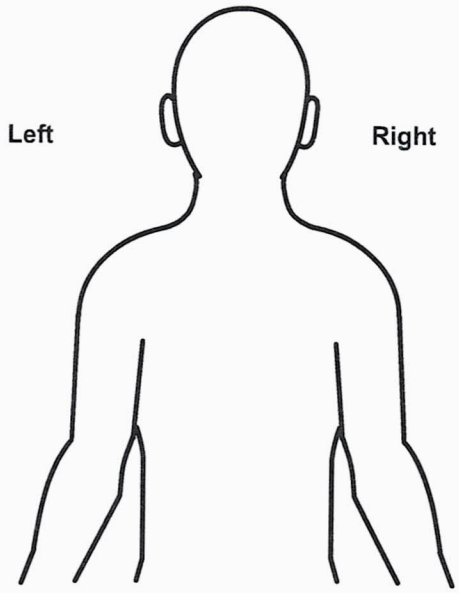
If yes, please complete Trauma History Section, enclosed as a separate form.

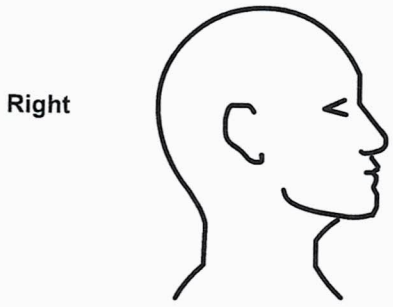
I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

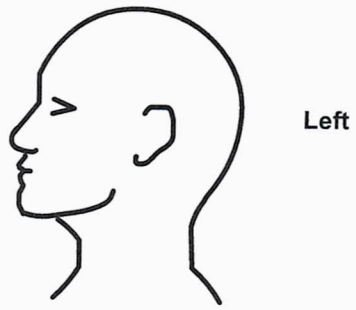
Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient is a minor):_____ Date: _____









Indicate Areas of Pain
Following the Pain Scale:
1 Mild pain
2 Moderate pain
3 Severe pain

DISCOMFORT SCALE

Patient Name: _____ Date: _____

Pain Discomfort Scales:

These are discomfort scales, for each part of the body there are two horizontal rows, one for the left and on for the right. Report the average discomfort over the last seven days by circling a rating from 0 to 10 which best reflects your discomfort. If you have discomfort on both sides, circle both rows for that body part.

		None										Severe
Bite Symptoms or Bite Changes	Left	0	1	2	3	4	5	6	7	8	9	10
	Right	0	1	2	3	4	5	6	7	8	9	10
TM Joint Pain	Left	0	1	2	3	4	5	6	7	8	9	10
	Right	0	1	2	3	4	5	6	7	8	9	10
TM Joint Sounds	Left	0	1	2	3	4	5	6	7	8	9	10
	Right	0	1	2	3	4	5	6	7	8	9	10
Headache	Left	0	1	2	3	4	5	6	7	8	9	10
	Right	0	1	2	3	4	5	6	7	8	9	10
Facial Pain	Left	0	1	2	3	4	5	6	7	8	9	10
	Right	0	1	2	3	4	5	6	7	8	9	10
Eye Symptoms	Left	0	1	2	3	4	5	6	7	8	9	10
	Right	0	1	2	3	4	5	6	7	8	9	10
Ear Pain	Left	0	1	2	3	4	5	6	7	8	9	10
	Right	0	1	2	3	4	5	6	7	8	9	10
Stuffy Ear or Ringing sounds	Left	0	1	2	3	4	5	6	7	8	9	10
	Right	0	1	2	3	4	5	6	7	8	9	10
Neck Pain	Left	0	1	2	3	4	5	6	7	8	9	10
	Right	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand/Finger Numbness/pain	Left	0	1	2	3	4	5	6	7	8	9	10
	Right	0	1	2	3	4	5	6	7	8	9	10
Upper Back Pain	Left	0	1	2	3	4	5	6	7	8	9	10
	Right	0	1	2	3	4	5	6	7	8	9	10
Lower Back Pain	Left	0	1	2	3	4	5	6	7	8	9	10
	Right	0	1	2	3	4	5	6	7	8	9	10
Overall Pain Score		0	1	2	3	4	5	6	7	8	9	10

Changes since last visit: _____

_____

_____

Patient Signature: _____

Daytime Sleepiness Evaluation

Epworth Sleepiness Scale

The Epworth Sleepiness Scale was developed and validated by Dr. Murray Johns of Melbourne Australia. It is a simple, self-administered questionnaire –widely used by sleep professionals in quantifying the level of daytime sleepiness.

For the following situations, answer with one of the following numbers:

0 - Would never doze

1 - slight chance of dozing

2 - moderate chance of dozing

3 - high chance of dozing

Situation	**Score**
Sitting and reading	
Watching Television	
Sitting, inactive in a public place	
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	

Patient Name _____

Date _____

AUTHORIZATION TO RELEASE INFORMATION TO THE BELOW LISTED REFERRING AND TREATING HEALTH CARE PROFESSIONALS:

Doctors Name **Location/Phone**

_____

_____

_____

_____

_____

_____

_____

I authorize the release of communications regarding my treatment with _____ including a full report of examination findings, diagnosis, treatment plan, and progress reports to the providers listed above.

Signed _____ Date _____