Facial Problem(s) Questionnaire

Full Legal Name: _____ **Birth Date:** _____

Referred by: _____

Referring Dr's Phone#: _____

Referring Dr's Email address: _____

GEORGIA DENTAL MEDICINE

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For Doctor Notes Below:

Please answer these questions to the best of your ability:

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

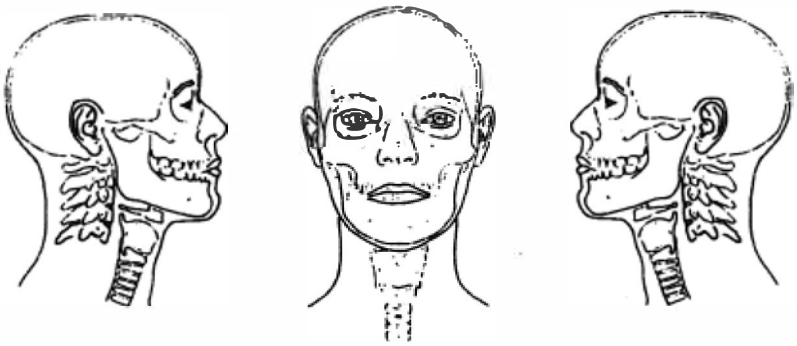
   Headaches **Neck Pain** **Jaw Pain** **Ear Pain**

   Facial Pain **Bite Problems** **Damaged teeth**

   Sleep Problem

   Other: _____

2. How many days a month are you pain free? _____
3. If pain free all of the time, please go to question 12 (Medications questions) below.
4. On the diagram below, draw an arrow(s) to indicate the location(s) of your trauma and pain:



Left side **Front** **Right side**

5. How long have you had this pain? _____
6. Is the pain constant? _____
7. Is the pain (circle all that apply):

   Aching **Burning** **Stabbing** **Sharp** **Dull**

   Other: _____

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8. Is the paint worse in the (circle all that apply):

Morning Afternoon Evening Night

9. What makes the pain better? _____

10. What makes the pain worse? _____

11. How severe is your pain (mark below):

|----------|

No pain Worst Ever!

12. What medications do you take now or have previously taken for your pain:

Medication	Dosage	Frequency	Still Taking?
_____	_____	_____	**YES or NO**
_____	_____	_____	**YES or NO**
_____	_____	_____	**YES or NO**
_____	_____	_____	**YES or NO**
_____	_____	_____	**YES or NO**
_____	_____	_____	**YES or NO**

13. Any discomfort when you chew? **YES or NO**
14. Is it difficult or painful to swallow? **YES or NO**
15. Any discomfort when you move your jaw? **YES or NO**
16. Any discomfort chewing hard foods like carrots? **YES or NO**
17. Do your jaw muscles get tired from chewing? **YES or NO**
18. Does it hurt to open your mouth wide? **YES or NO**

19. Which side of you jaw makes a clicking/popping noise (circle one)?

Right Left Neither

20. Which side of your jaw makes other noises?

Right Left Neither
Can you describe the noise? _____

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For Doctor Notes Below:

21. When did you first notice the noises/clicking? _____

22. Have you noticed any changes in the noises/clicking? **YES or NO**
Explain: _____

23. Ever not been able to open your jaw all the way open? **YES or NO**

24. Have you ever had to wiggle your jaw to get it open? **YES or NO**

25. Has your jaw ever been stuck open and you could not close it? **YES or NO**
If Yes: when did this first happen? _____
Last time it happened? _____

26. Has your speech noticeably changed? **YES or NO**

27. Have you noticed a change in the way your teeth come together? **YES or NO**

28. Have you noticed your teeth shifting? **YES or NO**

29. Has the shape of your face changed? **YES or NO**

30. Has your chin shifted to one side of your face? **YES or NO**

31. When did you notice a speech, shifting change?
Approximate Date: _____

32. Do you have a hyper-sensitive bite? **YES or NO**

33. Is your bite uncomfortable? **YES or NO**

34. When you close your jaw, do you have to search for a comfortable position for your teeth to fit? **YES or NO**

35. Are your teeth sore or sensitive? **YES or NO**

36. Do you clench your teeth? **YES or NO**

37. Do you grind your teeth? **YES or NO**

38. When do you grind or clench your teeth (circle all that apply)?
Day **Night** **Both** **Neither**
Do you remember when this started? _____

39. Do you have a dentist that you see regularly for routine care and cleanings? **YES or NO**
If Yes, Dentist's Name:_____ Last visit:_____

40. Which of the following dental procedures have you had (circle those that apply)?

- Fillings
- Crowns
- Orthodontics (braces)
- Bridge(s)
- Root Canal
- Dentures
- Bite Adjustment
- Tooth extraction
- Split or broken tooth

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For Doctor Notes Below:

41. Have you ever had braces? **YES or NO**
if YES answer these questions:

- How many times have you had braces? _____
- How old were you when you got braces? _____
- How old were you when you were done? _____

42. Do you feel that there is any connection between the dental work you have had done in the past and the problems you are having now? **YES or NO**

43. 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 you did have past trauma, you will also need to complete the "Trauma Questionnaire" after completing the rest of this questionnaire.

44. Have you ever had stiches in your chin? **YES or NO**

45. Do you feel there is any connection between the trauma you have had and the problems/pain you are having? **YES or NO**

46. Do you get headaches? **YES or NO**
How long to they last? _____
Where does it ache? _____

47. Have you had any changes in your vision? **YES or NO**

48. Do you get visual disturbances along with headaches**?** **YES or NO**

49. When was the last time you had your eyes checked? _____

50. Do you have problems with your ears?
If Yes then do you have:

- Dizziness? **YES or NO**
- Ringing in your ears? **YES or NO**
- Hearing loss? **YES or NO**
- Other? _____

51. Have you noticed any lumps in your face, throat or neck? **YES or NO**

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For Doctor Notes Below:

52. Do you have any sinus problems? **YES or NO**
If Yes, **explain**: _____

53. Do you have trouble sleeping? **YES or NO**
54. Do you feel rested when you wake up? **YES or NO**
55. How many hours do you sleep on average? _____
56. How long does it take for you to fall asleep? _____
57. How many times do you awake during the night? _____
58. Do you take any medications to help you sleep? **YES or NO**
If YES, please list: _____
59. What is your overall daily energy level (circle one):
Low **Less than before** **Normal** **High**

60. Do you snore? **YES or NO**
61. Do you have a sleep partner? **YES or NO**
- **If YES**: does your sleep partner snore? **YES or NO**
- **If YES**: do you sleep in a separate room?
YES **NO** **Sometimes**

59. Do you have trouble breathing during sleep? **YES or NO**
60. Have you ever woken up gasping or choking? **YES or NO**

61. Do you consider yourself under a lot of stress? **YES or NO**
62. Do you worry a lot? **YES or NO**
63. Do you ever get depressed? **YES or NO**
If YES, how often: _____

64. Have you ever had a stomach problem? **YES or NO**
65. Have you ever had Ulcers? **YES or NO**
66. Rate your diet. Is it (circle one):
Excellent **Good** **Could be better** **Poor**

67. Do you use vitamins, supplements, etc? **YES or NO**
If YES, list them below:
_____
_____
_____

68. Do you exercise regularly (2 or more per week)? **YES or NO**

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For Doctor Notes Below:

69. Do you currently use (circle each):
Caffeine **Tobacco products** **Alcohol**

70. Tiredness: How likely are you to dose off in the following situations? Use this scale to choose 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

- Sitting and reading _____
- Watching TV _____
- Sitting inactive in a public place _____
- As auto passenger 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 _____
- Driving and stopped for a few minutes in traffic _____

71. Do you have arthritis? **YES or NO**
72. Does anyone related to you have arthritis? **YES or NO**
73. Are your fingers ever sore or stiff? **YES or NO**
74. Do you have any dry skin patches? **YES or NO**
75. Have you been treated for any other painful condition in the last three years other than your present problem? **YES or NO**
Explain: _____

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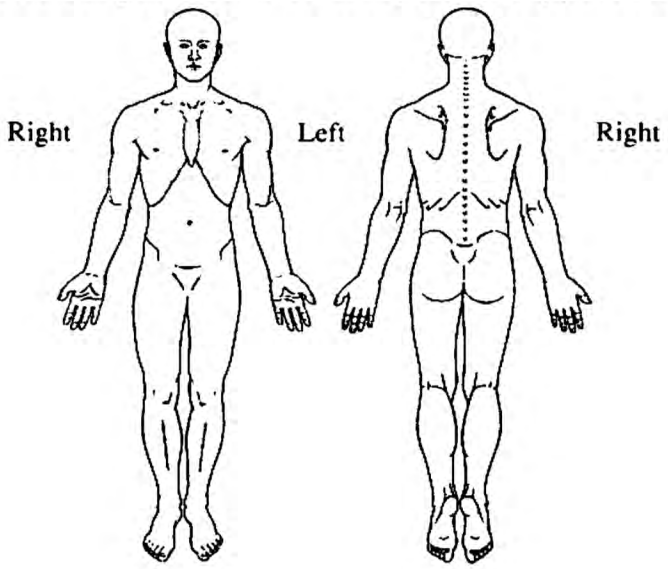
For Doctor Notes Below:

76. On the diagram below indicate any other area(s) that are painful:



77. Have you had any prior treatment for TMJ problems? **YES or NO**

78. Have you had:

Appliance/Splint **Y or N** When? _____ Did it help? **Y or N**
Night Guard? **Y or N** When? _____ Did it help? **Y or N**
Bite Adjustment? **Y or N** When? _____ Did it help? **Y or N**
Orthodontics? **Y or N** When? _____ Did it help? **Y or N**
Other: _____

79. Please list, in chronological order the healthcare providers you have seen for the problem you are having today:

Date	Doctor or Provider	Treatment	Did it Help?
_____	_____	_____	**YES or NO**
_____	_____	_____	**YES or NO**
_____	_____	_____	**YES or NO**
_____	_____	_____	**YES or NO**
_____	_____	_____	**YES or NO**
_____	_____	_____	**YES or NO**
_____	_____	_____	**YES or NO**
_____	_____	_____	**YES or NO**

80. Describe your problem(s) in your own words:

_____

_____

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For Doctor Notes Below:

81. How have this problem(s) affected your life? I.E. What does it keep you from doing?

_____

_____

_____

82. What would you like to accomplish with treatment here?

_____

_____

_____

83. What changed and When? So that we may better understand your problem(s), please list in chronological order with date estimates, all of the changes and/or defining moments of your problem.
(Examples are: fell down stairs, left TMJ started clicking after <something>, teeth shifted, headaches increased, etc.):

Estimated Date	Change that occurred
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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For Doctor Notes Below:

84. Is there anything else that we should know about your problem(s)?

_____

_____

_____

_____

85. So that we can better understand your pain, circle any of the words below that describe your present pain. Each individual box describes an increasing amount of "pain" in an ascending order. Circle one word in each box that applies:

Flickering	Jumping	Pricking	Sharp	Pinching
Quivering	Flashing	Boring	Cutting	Pressing
Paulsing	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	Spitting	Heavy
			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
Unbearble		Tearing		Torturing

Thank you for completing all questions above in this questionnaire.

I have completed the above questionnaire to the best of my knowledge and I personally have answered each question truthfully.

Signature: _____ **Date:** _____