TMJ & Sleep
Therapy Centre

Patient Health Questionnaire

Today's Date: _____

Demographic Information

Last Name: _____ Middle Initial: _____ First Name: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Age: _____ Date of Birth: _____ SSN: _____ Sex: ☐ Male ☐ Female

Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Decline

Occupation: _____

Responsible Party/Legal Guardian (if different than patient): _____ Relationship to Patient: _____

Contact Information

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Employer: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Referral Information - how did you hear about us?

Referral Name/Source: _____

Referral Type: ☐ Doctor ☐ Dentist ☐ Specialist ☐ Patient ☐ Other _____

Provider Information

Dental Provider Office: _____ Last Visit: _____

Dentist Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

Primary Care Physician Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

Additional Provider Office (if applicable): _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

Additional Provider Office (if applicable): _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

For Office Use Only - Date of Completion: _____

Patient Initials: _____

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Current Symptoms

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

Please number your chief complaint as 1 and all other complaints starting at 2 and increasing numerically:

___Back Pain	___Neck Pain	___Frequent Tossing & Turning
___Difficulty Closing Mouth	___Nerve Pain	___Kicking/Jerking Legs Repeatedly
___Dizziness	___Numbness	___Morning Headaches
___Dyskinesia	___Pain When Chewing	___Morning Hoarseness in Voice
___Ear Congestion	___Shoulder Pain	___Night Sweats
___Ear Pain	___Sinus Congestion	___Nighttime Choking Spells
___Ear Stuffiness	___Throat Pain	___Nighttime Urination
___Eye Pain	___Tinnitus (Ringing in Ears)	___Repeated Awakening
___Facial Pain	___Vision Problems	___Short of Breath
___Headache (inside head)	___Acid Indigestion	___Sore Jaw Upon Waking
___Headache (outside head)	___Affecting Sleep Partner	___Swelling in Ankles/Feet
___Jaw Joint Locking	___Difficulty Falling Asleep	___Teeth Crowding
___Jaw Joint Noises	___Dry Mouth Upon Waking	___Teeth Grinding
___Jaw Pain	___Fatigue	___Told I Stop Breathing During Sleep
___Limited Ability to Open	___Feel Unrefreshed in Morning	___Unable to Tolerate CPAP
___Muscle Twitching	___Frequent Heavy Snoring	___Vivid Dreams

What is your level of head, neck, and facial pain? *0 = no pain to 10 = worst possible pain:*

Currently: _____ At its best: _____ At its worst: _____

What results are you seeking from treatment? _____

_____

Please check any dental symptoms that you are currently experiencing:

___Changes in bite	___Teeth Crowding	___Teeth Spacing
___Dental Changes	___Teeth Sensitivity	___None

Any symptoms not listed above? _____

_____

_____

In which position do you sleep?	☐ back	☐ side	☐ stomach	☐ varies
Where do you sleep?	☐ bed	☐ chair	☐ couch	☐ other
Do you have a bed partner?	☐ yes	☐ no		
Is it easy for you to fall asleep?	☐ yes	☐ no		
How many times do you wake during the night?	_____			
Do you feel rested upon waking?	☐ yes	☐ no		
Has anyone ever told you that you stop breathing during sleep?	☐ yes	☐ no		
Have you ever had a sleep study?	☐ yes	☐ no		

If yes: Date: _____ Location: _____

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Medications

Please list all medications you are currently taking and the reason you are taking the. Include prescription, over the counter, vitamins, herbs, etc. (Please attach additional sheet if necessary)

Medication	Dosage	Reason for Taking

Previous treatments/medications for the condition we are evaluating:

Treatment/Medication	Doctor/Provider	Approximate Date of Treatment

☐ TMJ & Sleep Therapy Centre has my permission to obtain my complete medication history, including electronic prescription submission

Allergies

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

___Anesthetics
___Antibiotics
___Aspirin
___Barbiturates
___Codeine
___Iodine
___Latex
___Metals
___Penicillin
___Plastic
___Sedatives
___Sulfa

Other:_____

Medical History

Have you had prior orthodontic treatment? ☐ yes ☐ no

Have you had sustained injury to: ☐ head ☐ face ☐ neck ☐ teeth

Other:_____

Please indicate if you have had any of the following:

___General Anesthesia
___Adenoids Removed
___Tonsils Removed
___Jaw Joint Surgery
___Orthognathic Surgery
___Oral Surgery
___Removal of Wisdom Teeth
___Nasal Surgery

Other Surgeries:_____

Do you have trouble breathing through your nose? ☐ yes ☐ no

Are you currently pregnant? ☐ yes ☐ no

Do you drink 4 or more cups of coffee per day? ☐ yes ☐ no

Do you smoke tobacco? ☐ yes ☐ no

Do you consume alcohol? ☐ yes ☐ no

if yes: ☐ habitually ☐ socially

Do you take any sedatives/medications/supplements to help yourself fall asleep at night? ☐ yes ☐ no

If yes, what: _____

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Medical History, Continued

Have you ever experienced: ___Physical Abuse ___Verbal Abuse ___Emotional Abuse ___Sexual Abuse ___None
(Optional - check applicable)

If yes, please explain (optional):_____

Do you have or have you experienced any of the following?

___AIDS/HIV
___Anemia
___Anxiety
___Asthma
___Birth Defects
___Bleeding Easily
___Bruising Easily
___Cancer
___Chronic Fatigue
___Cold Hands and Feet
___Depression
___Diabetes
___Difficulty Breathing at Night
___Difficulty Concentrating
___Dizziness
___Eating Disorder
___Ehlers-Danlos Syndrome (EDS)
___Emphysema
___Epilepsy
___Excessive Thirst
___Fainting
___Fibromyalgia
___Fluid Retention
___Frequent Awakening at Night
___Frequent Colds/Flus
___Frequent Cough
___Frequent Ear Infections
___Frequent Sore Throat
___Gastroesophageal Reflux (GERD)
___Glaucoma
___Hay Fever
___Hearing Impairment
___Heart Disorder/Heart Attack
___Heart Murmur
___Heart Pacemaker
___Heart Palpitations
___Heart Valve Replacement
___Hemophilia
___Hepatitis
___High Blood Pressure
___History of Substance Abuse
___Huntington's Disease
___Hypoglycemia
___Insomnia
___Intestinal Disorder
___Irregular Heartbeat
___Kidney Disease
___Leukemia
___Liver Disease
___Low Blood Pressure
___Memory Loss
___Meniere's Disease
___Migraines
___Mitral Valve Prolapse
___Muscle Aches
___Muscular Dystrophy
___Muscle Fatigue
___Muscle Spasms
___Muscle Tremors
___Multiple Sclerosis
___Nervous System Disorder
___Neuralgia
___Osteoarthritis
___Osteoporosis
___Ovarian Cyst
___Parkinson's Disease
___Poor Circulation
___Postural Orthostatic Tachycardia Syndrome (POTS)
___Psychiatric Care
___Recent Weight Gain
___Recent Weight Loss
___Rheumatoid Arthritis
___Rheumatoid Fever
___Scarlet Fever
___ Seizures
___Shortness of Breath
___Significant Daytime Drowsiness
___Sinus Problems
___Skin Disorder
___Slow Healing Sores
___Sleep Apnea
___Speech Difficulties
___Stroke
___Swollen, Stiff, or Painful Joints
___Thyroid Problem
___Tired Muscles
___Tuberculosis
___Urinary Tract Disorder

Does your family have a history of similar conditions, symptoms, or diseases? ☐ yes ☐ no

If yes, who:_____

Have you been prescribed a CPAP? ☐ yes ☐ no
Do you use it as prescribed? ☐ yes ☐ no
Have you had a previous oral appliance, mouthguard, splint, retainer? ☐ yes ☐ no
Do you use it as prescribed? ☐ yes ☐ no
How many hours of sleep, on average, do you get per night? _____
How many hours of sleep, on average, during the day? _____
Do you ever cough, gasp, or snort upon waking? ☐ yes ☐ no

Patient Initials: _____

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Currently Experiencing

Are you currently experiencing head pain? ☐ yes ☐ no

If yes, please indicate all that apply:

	Location			Time Frame		Severity			Duration			Frequency		
	Left	Right	Bilateral	Recent	Chronic (over 6 mo.)	Mild	Moderate	Severe	Min.	Hrs.	Days	Occasional	Frequent	Constant
Temple Area (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Back of Head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Forehead (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Top of Head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
General Head Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are you currently experiencing jaw conditions? ☐ yes ☐ no

If yes, please indicate all that apply:

Jaw pain with opening	☐ left	☐ right
Jaw pain when chewing	☐ left	☐ right
Jaw pain at rest	☐ left	☐ right
Jaw sounds with opening	☐ left	☐ right
Jaw sounds when chewing	☐ left	☐ right
Jaw sounds at rest	☐ left	☐ right

Please indicate if you have had any of the following:

___Jaw Locks Closed
___Jaw Locks Open
___Daytime Teeth Clenching/Grinding
___Nighttime Clenching/Grinding
___Blurred Vision
___Double Vision
___Pain/Pressure behind eyes
___Extreme Sensitivity to light
___Wear Glasses or Contact Lenses

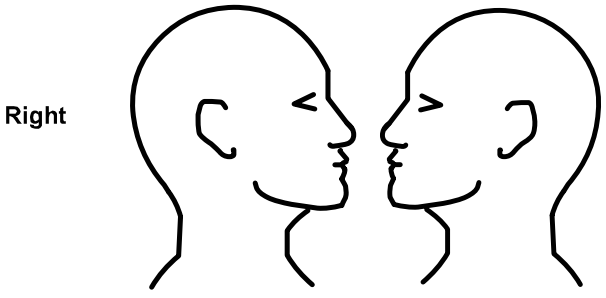
Are you currently experiencing any ear related conditions? ☐ yes ☐ no

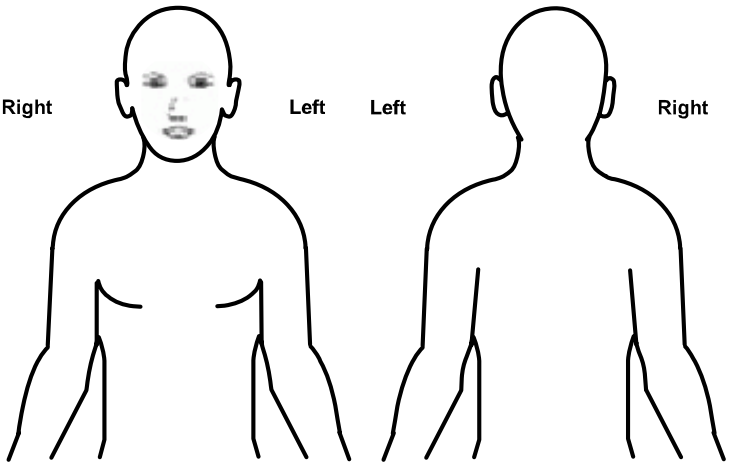
If yes, please indicate all that apply:

Ear Congestion	☐ left	☐ right
Ear Pain	☐ left	☐ right
Hearing Loss	☐ left	☐ right
Itchiness or Stuffiness in Ears	☐ left	☐ right
Pain Behind the Ear	☐ left	☐ right
Pain in Front of the Ear	☐ left	☐ right
Recurrent Ear Infections	☐ left	☐ right
Ringing in the Ear	☐ left	☐ right

Please indicate your areas of pain by labeling the body and head diagrams with the appropriate numbers below.

1 - Mild Pain	2 - Moderate Pain	3 - Severe Pain





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Please indicate if you have had any of the following:

___Chronic Sore Throat
___Difficulty Swallowing
___Swollen Gland
___Thyroid Enlargement
___Tightness in Throat
___Constant Feeling of Foreign Object in Throat
___Limited Movement of Neck
___Neck Pain
___Numbness in hands/fingers
___Swelling in the neck
___Shoulder Pain
___Shoulder Stiffness
___Tingling in hands or fingers
___Lower Back Pain
___Upper Back Pain
___Middle Back Pain
___Scoliosis
___Sciatica
___Chronic Sinusitis
___Broken Teeth
___Dry Mouth
___Frequent Biting of the Cheek
___Burning Tongue Sensation

Symptom History

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

Can you relate your pain/condition to a motor vehicle accident or traumatic injury? ☐ yes ☐ no

If yes, please explain: _____

Does any family member have a sleep breathing disorderor Obstructive Sleep Apnea? ☐ yes ☐ no

If yes, who: _____

Does any family member have the same or a similar problem? ☐ yes ☐ no

If yes, please explain: _____

Additional Information

Is there anything else you would like us to know?

_____

_____

_____

_____

_____

_____

_____

_____

Signature

I agree, the above information is accurate and complete to the best of my knowledge.

Patient Signature: _____Date: _____

Parent/Guardian Signature: _____Date: _____

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is a set of questions that have been used to evaluate the restfulness of a patient. Though it is not a true test that can prove you have sleep apnea, it is certainly can suggest that you are more prone to fall asleep than other and should be evaluated by a physician. The questions are useful assuming that you are sleeping regularly and are in your usual state of health.

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 Signature Date