



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: \_\_\_\_\_



**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:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Back Pain                | <input type="checkbox"/> Neck Pain                   | <input type="checkbox"/> Frequent Tossing & Turning         |
| <input type="checkbox"/> Difficulty Closing Mouth | <input type="checkbox"/> Nerve Pain                  | <input type="checkbox"/> Kicking/Jerking Legs Repeatedly    |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Numbness                    | <input type="checkbox"/> Morning Headaches                  |
| <input type="checkbox"/> Dyskinesia               | <input type="checkbox"/> Pain When Chewing           | <input type="checkbox"/> Morning Hoarseness in Voice        |
| <input type="checkbox"/> Ear Congestion           | <input type="checkbox"/> Shoulder Pain               | <input type="checkbox"/> Night Sweats                       |
| <input type="checkbox"/> Ear Pain                 | <input type="checkbox"/> Sinus Congestion            | <input type="checkbox"/> Nighttime Choking Spells           |
| <input type="checkbox"/> Ear Stuffiness           | <input type="checkbox"/> Throat Pain                 | <input type="checkbox"/> Nighttime Urination                |
| <input type="checkbox"/> Eye Pain                 | <input type="checkbox"/> Tinnitus (Ringing in Ears)  | <input type="checkbox"/> Repeated Awakening                 |
| <input type="checkbox"/> Facial Pain              | <input type="checkbox"/> Vision Problems             | <input type="checkbox"/> Short of Breath                    |
| <input type="checkbox"/> Headache (inside head)   | <input type="checkbox"/> Acid Indigestion            | <input type="checkbox"/> Sore Jaw Upon Waking               |
| <input type="checkbox"/> Headache (outside head)  | <input type="checkbox"/> Affecting Sleep Partner     | <input type="checkbox"/> Swelling in Ankles/Feet            |
| <input type="checkbox"/> Jaw Joint Locking        | <input type="checkbox"/> Difficulty Falling Asleep   | <input type="checkbox"/> Teeth Crowding                     |
| <input type="checkbox"/> Jaw Joint Noises         | <input type="checkbox"/> Dry Mouth Upon Waking       | <input type="checkbox"/> Teeth Grinding                     |
| <input type="checkbox"/> Jaw Pain                 | <input type="checkbox"/> Fatigue                     | <input type="checkbox"/> Told I Stop Breathing During Sleep |
| <input type="checkbox"/> Limited Ability to Open  | <input type="checkbox"/> Feel Unrefreshed in Morning | <input type="checkbox"/> Unable to Tolerate CPAP            |
| <input type="checkbox"/> Muscle Twitching         | <input type="checkbox"/> Frequent Heavy Snoring      | <input type="checkbox"/> 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:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Changes in bite | <input type="checkbox"/> Teeth Crowding    | <input type="checkbox"/> Teeth Spacing |
| <input type="checkbox"/> Dental Changes  | <input type="checkbox"/> Teeth Sensitivity | <input type="checkbox"/> None          |

Any symptoms not listed above? \_\_\_\_\_

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

If yes: Date: \_\_\_\_\_ Location: \_\_\_\_\_



### 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:

- |                                       |                                  |                                     |
|---------------------------------------|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Anesthetics  | <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Antibiotics  | <input type="checkbox"/> Iodine  | <input type="checkbox"/> Plastic    |
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Latex   | <input type="checkbox"/> Sedatives  |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Metals  | <input type="checkbox"/> Sulfa      |

Other: \_\_\_\_\_

### Medical History

Have you had prior orthodontic treatment?

Have you had sustained injury to:

- yes     no  
 head     face     neck     teeth

Other: \_\_\_\_\_

Please indicate if you have had any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> General Anesthesia | <input type="checkbox"/> Jaw Joint Surgery    | <input type="checkbox"/> Removal of Wisdom Teeth |
| <input type="checkbox"/> Adenoids Removed   | <input type="checkbox"/> Orthognathic Surgery | <input type="checkbox"/> Nasal Surgery           |
| <input type="checkbox"/> Tonsils Removed    | <input type="checkbox"/> Oral Surgery         |  |

Other Surgeries: \_\_\_\_\_

Do you have trouble breathing through your nose?

Are you currently pregnant?

Do you drink 4 or more cups of coffee per day?

Do you smoke tobacco?

Do you consume alcohol?

- yes     no  
 yes     no  
 yes     no  
 yes     no  
 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: \_\_\_\_\_

Patient Initials: \_\_\_\_\_



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

**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: \_\_\_\_\_



**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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back of Head (Occipital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forehead (Frontal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Top of Head (Parietal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General Head Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

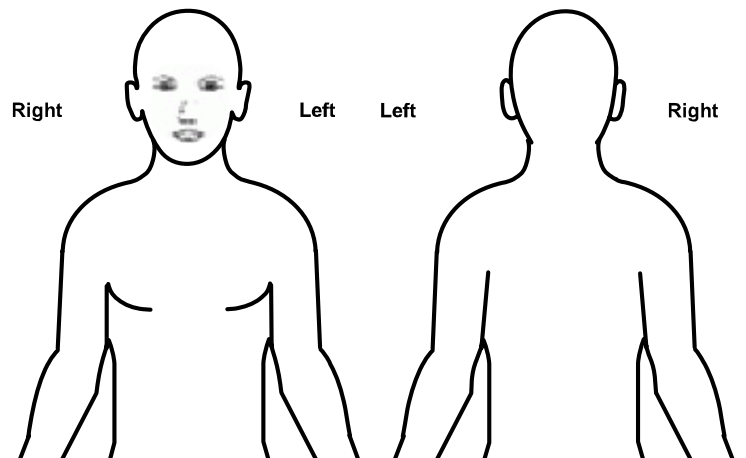
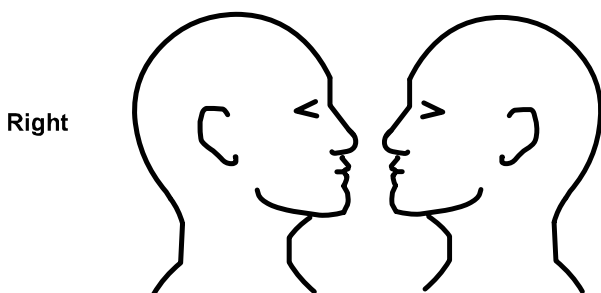
Are you currently experiencing any ear related conditions?  yes  no

If yes, please indicate all that apply:

- Ear Congestion  left  right
- Ear Pain  left  right
- Hearing Loss  left  right
- Itchiness or Stiffness 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



Patient Initials: \_\_\_\_\_



**Please indicate if you have had any of the following:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chronic Sore Throat                             | <input type="checkbox"/> Neck Pain                    | <input type="checkbox"/> Middle Back Pain             |
| <input type="checkbox"/> Difficulty Swallowing                           | <input type="checkbox"/> Numbness in hands/fingers    | <input type="checkbox"/> Scoliosis                    |
| <input type="checkbox"/> Swollen Gland                                   | <input type="checkbox"/> Swelling in the neck         | <input type="checkbox"/> Sciatica                     |
| <input type="checkbox"/> Thyroid Enlargement                             | <input type="checkbox"/> Shoulder Pain                | <input type="checkbox"/> Chronic Sinusitis            |
| <input type="checkbox"/> Tightness in Throat                             | <input type="checkbox"/> Shoulder Stiffness           | <input type="checkbox"/> Broken Teeth                 |
| <input type="checkbox"/> Constant Feeling of Foreign<br>Object in Throat | <input type="checkbox"/> Tingling in hands or fingers | <input type="checkbox"/> Dry Mouth                    |
| <input type="checkbox"/> Limited Movement of Neck                        | <input type="checkbox"/> Lower Back Pain              | <input type="checkbox"/> Frequent Biting of the Cheek |
|  | <input type="checkbox"/> Upper Back Pain              | <input type="checkbox"/> 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 disorder or 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?

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**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***

<b>Situation</b>	<b>Score</b>
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	
<b>Total Score</b>	

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



## STOP-Bang Questionnaire

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Yes No **S**noring?  
  Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?

Yes No **T**ired?  
  Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?

Yes No **O**bserved?  
  Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?

Yes No **P**ressure?  
  Do you have or are being treated for **High Blood Pressure**?

Yes No  
  **B**ody Mass Index more than 35 kg/m<sup>2</sup>?

Yes No  
  **A**ge older than 50 year old?

**N**eck size large? (Measured around Adams apple)  
Yes No For male, is your shirt collar 17 inches/43 cm or larger?  
  For female, is your shirt collar 16 inches/41 cm or larger?

Yes No  
  **G**ender = Male?

### Scoring Criteria:

For general population:

0-2 affirmative responses - low risk of OSA

3-4 affirmative responses - intermediate risk of OSA

5-8 affirmative responses - high risk of OSA