



Medical and Dental History

Craniofacial Pain, Temporomandibular Orthopedics and Obstructive Sleep Apnea Questionnaire

Patient's Name _____ Date _____

This confidential detailed medical-dental history should be completed so that we may analyze your needs in regard to your headache, neckache, facial and TMJ pain areas. Please take the necessary time to complete the questionnaire. Thank you for your cooperation. All 27 questions must be answered where applicable and then the questionnaire signed.

1. Please list your chief medical/dental complaint and the main reason for seeking care with us. _____

2. Who referred you for the problem? What previous diagnosis has been made? _____

3. Who else have you seen for this problem? Please list all specialists, city/location and dates seen. _____

Use a separate sheet if history is extensive. Total doctors/clinicians seen for main problem. _____

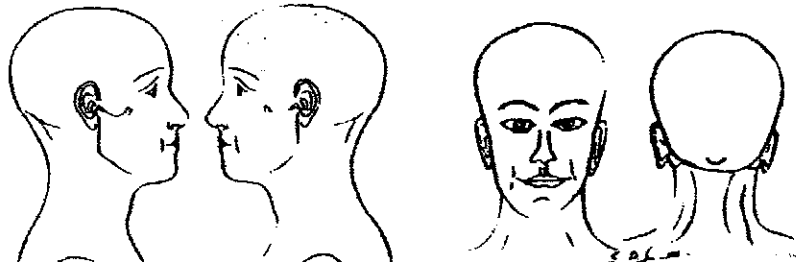
4. What significant findings came from past evaluations with these specialists related to your main problem/chief complaint? _____

5. What past treatment has helped you the most related to your chief complaint? _____

6. When did pain first begin and what do **you** think or suspect is the cause? _____

7. Please describe and draw location of trigger areas where pain starts (X) and referred point where pain spreads to (—>) in the head/neck/face region.

Right Side Left Side Front Back



8. describe what tends to relieve these pains or stress areas. What worsens it? _____

9. On a pain/soreness scale of 1 to 10 (10 = worst intense pain), give a current number rating to each of the following areas:

- | | | | | | |
|------------------------------------|------------------------------------|---------------------------------------|---------------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> face | <input type="checkbox"/> lower jaw | <input type="checkbox"/> back of head | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> mid-back | <input type="checkbox"/> groin |
| <input type="checkbox"/> eyes | <input type="checkbox"/> teeth | <input type="checkbox"/> neck | _____ | <input type="checkbox"/> lower back | <input type="checkbox"/> hips |
| <input type="checkbox"/> forehead | <input type="checkbox"/> temples | <input type="checkbox"/> mouth | _____ | <input type="checkbox"/> chest | <input type="checkbox"/> arms |
| <input type="checkbox"/> sinuses | <input type="checkbox"/> ears | <input type="checkbox"/> tongue | _____ | <input type="checkbox"/> abdomen | <input type="checkbox"/> legs |
| <input type="checkbox"/> upper jaw | <input type="checkbox"/> TM Joints | <input type="checkbox"/> throat | <input type="checkbox"/> shoulders | <input type="checkbox"/> menstrual | <input type="checkbox"/> hands |
| | | | | | <input type="checkbox"/> feet |

10. Do you have any present (x) or past (indicate date) medical problem with any of the following systems?

- | | | | | |
|----------------------|--------------------|---------------------------|--------------------------|--------------------|
| _____ lungs | _____ insulin | _____ sugar metabolism | _____ hearing (aid) | _____ mental |
| _____ heart | _____ adrenals | _____ lymph, blood | _____ brain | _____ emotional |
| _____ blood pressure | _____ bladder | _____ muscular | _____ taste/smell | _____ reading |
| _____ liver | _____ reproductive | _____ skeletal | _____ speech | _____ visual |
| _____ kidney | _____ nervous | _____ vascular | _____ dental | _____ sleeping |
| _____ pancreas | _____ salivary | _____ allergy | _____ walking | _____ depression |
| _____ writing | _____ oral | _____ antigen-antibody | _____ swallowing/chewing | _____ intense fear |
| _____ thyroid | _____ stomach | _____ equilibrium/balance | _____ learning | _____ Other(?) |

Describe past or present diseases or limitations of the above. _____

_____ Mitral Valve Prolapse (MVP)? _____

11. Age ___ Height ___ Weight ___ Do you wear corrective eyeglasses? ___ Wear foot orthotics? ___ Heel lift/wedge? ___
 Wear cervical collar or brace? ___ Wear a nightguard? ___ Wear dentures? ___ Wear a TMJ oral splint/appliance? ___

12. Please **check** the following symptoms of which you are **presently** aware. Please **circle** past symptoms.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> headache | <input type="checkbox"/> ear ache | <input type="checkbox"/> restrictive head | <input type="checkbox"/> neck spasm |
| <input type="checkbox"/> vertigo | <input type="checkbox"/> dizziness | and jaw movement | <input type="checkbox"/> spotting/menstrual irreg. |
| <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> ringing/tinnitus | <input type="checkbox"/> arthritic joints | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> over weight | <input type="checkbox"/> neuralgia | <input type="checkbox"/> stiff shoulder | <input type="checkbox"/> excessive tiredness & fatigue |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> eustachian tube blockage | <input type="checkbox"/> back ache | <input type="checkbox"/> difficulty sleeping |
| <input type="checkbox"/> muscle tension pain | <input type="checkbox"/> bloating | <input type="checkbox"/> sore mouth | <input type="checkbox"/> light sensitive |
| <input type="checkbox"/> jaw soreness | <input type="checkbox"/> sinus area pain | <input type="checkbox"/> hearing loss | <input type="checkbox"/> recent weight loss |
| <input type="checkbox"/> ulcers | <input type="checkbox"/> fainting | <input type="checkbox"/> dry mouth | <input type="checkbox"/> sensitive to weather |
| <input type="checkbox"/> bruxism/grinding | <input type="checkbox"/> clicking/popping TM Joints | <input type="checkbox"/> facial tic/pain | or barometric change |
| <input type="checkbox"/> toothache | <input type="checkbox"/> migraine area pain | <input type="checkbox"/> burning tongue | <input type="checkbox"/> excessive urination |
| <input type="checkbox"/> chewing pains | <input type="checkbox"/> snoring | <input type="checkbox"/> tremors | <input type="checkbox"/> gas & indigestion |

13. Are you missing teeth? ___ Do you have a deep overbite? ___ Are your jaws imbalanced? ___ Describe your oral health and dentition. _____

14. List past surgery and any hospitalizations within the past 5 years. _____

Women: Are you pregnant? Yes No Miscarriage history? Yes No Hysterectomy? Yes No

15. Check which tests you have had and the date.

<u>Test</u>	<u>Dates</u>	<u>Describe related abnormal findings</u>
Brain scan	_____	_____
Electro Encephalogram	_____	_____
Echocardiograph (heart valves)	_____	_____
TB Tests	_____	_____
Endocrine or Thyroid tests	_____	_____
CAT Scan	_____	_____
MRI (Magnetic Resonance Imaging)	_____	_____
Tomograms, Skull or Cranial	_____	_____
TM Joint X-Rays	_____	_____
Angiogram-Arterial X-Ray Study	_____	_____
Myelogram, Spinal	_____	_____
Vascular Analysis	_____	_____
Neurosensory Evaluation	_____	_____
ENT, hearing, audiogram or equilibrium test	_____	_____
Psychiatric treatment	_____	_____
Blood Chemistry	_____	_____
Hair, Mineral analysis	_____	_____
Dietary, Bio-Nutritional Analysis	_____	_____

Overnight Sleep Study/Polysomnogram _____

16. Which of the following do you frequently find?

- A. thyroid/endocrine difficulty? Describe: _____

- B. failure to gain weight
 hyperthyroid problem
 hypothyroid problem
- C. cold intolerance
 excessive perspiration
- nervousness
 heartbeat fluctuation
 sleeplessness
 frequent bowel movements
 large appetite
 goiter swelling
 large swollen eyes
 pelvic muscle atrophy
 limb muscle weakness
 hair loss
- dry skin
 weigh gain tendency
 fatigue
 sluggish energy level
 muscle weakness
 cramps of muscles
 sleepiness
 forgetfulness
 memory loss
 mental dullness

17. A. List immunizations & dates

B. Current drugs and medications

C. Allergies

18. Evaluate and describe your nervous system and reaction to stress. Are your extremities cold or susceptible to numbing or tingling? Fatigue? _____

19. Describe any past trauma including head/neck area accidents or falls and dates. _____

20. Are you on any other drugs or marijuana? _____ Do you have over two alcoholic drinks per day? _____ Amount? _____
Do you smoke? _____ How much? _____ Describe: _____

21. Have you ever been (a) seriously depressed or (b) considered committing suicide? Describe: _____

Where applicable: Dates of visits to psychiatrist; diagnosis? _____

22. Family History:

a. Did anyone in your family ever have sugar diabetes? _____

b. Did you or any of your children weigh more than 10 pounds at birth? _____

c. Did anyone in your family ever have fits of epilepsy or mental disease? _____

d. Is there a family history of: Heart Problems? _____ Cancer? _____
Stroke? _____ Hemophilia? _____ Other? _____

e. Are all of your children healthy? _____ List major health problems if applicable _____

f. Have your parents or close relatives died from any other than natural causes? If so, describe:
Mother _____ Age _____ Father _____ Age _____

g. Are any of your close relatives in poor health? _____ Describe _____

h. Does hypoglycemia (low blood sugar) run in your family? _____ Do you get faint or light-headed at mid-day? _____
What is your typical breakfast? _____

i. Are you or your family on a special diet? _____ Salt free? _____ Number of calories _____

j. Do you get much exercise? _____ Frequency? _____

k. Is your work stressful or do you enjoy it? _____

l. What are your main hobbies? _____

23. a. Did you have a high decay rate in your teens? _____ Current decay status? _____

b. Is your mouth in good shape? _____

c. Would you say you had good dentistry in the past? _____

d. Have you neglected your oral hygiene and general dental care? _____

e. Do you go regularly for six month or yearly dental check-ups? _____

f. Do you have all missing teeth replaced to complete your dental arches? _____

g. Which of the following dental procedures have you had performed? _____

Past Complications?

- | | | |
|---|------------------------------|-----------------------------|
| 1. restorative dentistry and fillings _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. orthodontics _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. extractions/oral surgery _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. root canal therapy/endodontics _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. crowns and/or fixed bridge work _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. partial removable dentures/prostodontics _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. gum surgery/periodontics _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. bite adjustments/equilibration _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. complete dentures _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

h. Do your gums bleed easily? _____ Describe _____

i. Do you frequently get sores or ulcerations in your mouth or on your lips? _____

j. Are your teeth sensitive to hot, cold or sweets? _____

24. Current dental needs:
- a. Are you happy with the appearance of your teeth? _____
 - b. Do you feel that any of your teeth must come out? _____
 - c. Do you want to save your teeth? _____
 - d. Do you feel you can do anything about saving your teeth? _____
 - e. How much time do you spend daily caring for your teeth and gums? _____
 - f. Does your under lying soft tissue and bone support change much over the years? _____

- g. Denture wearers:
- 1. How many dentures have you had? _____
 - 2. Were they satisfactory? _____
 - 3. Were they comfortable? _____
 - 3. Were they attractive in appearance? _____
 - 4. Could you chew well with them? _____
 - 5. How many "relines" have you had? _____
 - 6. Do you wish you could have implants to replace your teeth? _____

25. Assess your current dental needs by priorities. _____

26. Have you been told by doctors that your pain was imaginary or "all in your head?" _____

27. Do you expect to sue because of your pain or past health management? _____
 If yes, discuss specifics: _____

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Address _____ Apt. _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Birth Date _____ Social Security # _____ Married Single Male Female

Educational Level: High School College Post Graduate Occupation _____

Number of children/dependents _____ Ages _____

Family Physician _____ Family Dentist _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Phone # _____ Phone # _____

Medical Alert _____ Drug Allergies _____

Employer/Company Name _____

Address _____

City _____ State _____ Zip _____ Phone # _____

Policy/Group # _____ Local _____

Insurance Information: PRIMARY: (Check One) Medical Dental

Insurance Carrier _____ Employer ID # _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Contact Person _____

Insurance Information: SECONDARY: (Check One) Medical Dental

Insurance Carrier _____ Employer ID # _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Contact Person _____

Insured Information

First Name _____ MI _____ Last Name _____

Address _____ Apt. _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Birth Date _____ Social Security # _____ Married Single Male Female

Patient's Relationship to Insured: (check one) Insured Spouse Dependent

No-Fault (Auto Accident) Case Worker's Compensation Case Date of Accident/Trauma _____

Claim # _____ Your Lawyer _____

Carrier _____ Firm _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Phone # _____ Phone # _____

Claims Rep. _____

Office Financial Arrangements are to be made at the time of the treatment plan/cost estimate. Payment is expected at the time of visit unless other arrangements have been made. Our office will assist you to maximize your medical or dental insurance reimbursement. This office cannot render services on the assumption that the charges will be paid by an insurance plan; all insurance companies vary in their provisions and exclusions. I, the undersigned (patient or legally responsible party) authorize treatment to be rendered, and shall assume full financial responsibility. I authorize medical/dental record copies, when requested, to be sent to my treating doctors, and to my medical/dental/no-fault insurance carriers, where applicable. (A) It is understood that orthopedic models, radiographs, primary records, and photographs taken in the examination and treatment remain the property of Dr. Stephen David Smith. (B) Consent is given to the taking of pictures and use of all the above for scientific and/or educational purposes.

Patient Signature _____ Date _____