

HEALTH QUESTIONNAIRE ®

Patient Name: _____ Date: _____
 Chief Concern: _____

Date of Onset: _____

PAIN SYMPTOMS

Do you get headaches? Y N
 Do you get migraine headaches? Y N
 Do you frequently have neck aches or stiff neck muscles? Y N
 Have you ever had chronic shoulder or back pain? Y N
 Do you have trouble sleeping soundly? Y N
 Are your jaws tired when you awaken? Y N
 Have your wisdom teeth been extracted? Y N
 What medication if any are you taking? Y N

Do you get headaches in the right or left temple areas? Y N
 Do you get headaches in the front or back of the head? Y N
 Do you clench your teeth during the day or night? Y N
 Do you grind your teeth when you are asleep? Y N

When are your symptoms worst?

Does anything make you feel better?

How often do you take medications for relief of pain?

Any serious accidents, such as a car accident?

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw? Y N
 Any whiplash injuries? Y N

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal? Y N
 Are there any foods you avoid eating? Y N
 Do you ever get dizzy? Y N
 Do you ever feel faint? Y N
 Do you ever feel nauseated? Y N
 Is there a family history of jaw joint (TMJ) problems or headaches? Y N

Do you feel or hear a clicking, popping or cracking noise from either jaw joint? Y N
 Has your jaw ever locked when you were unable to open or close? Y N
 Do you have difficulty opening wide or yawning? Y N
 Have you ever had pain in either jaw joint? Y N
 Does your jaw ache when you open wide? Y N

Do you wear glasses or contacts? Y N
 Are there times when your eyesight blurs? Y N
 Do you get pain in, around or behind either eyes? Y N

EAR AND EYE SYMPTOMS

Do you have pain in either ear? Y N
 Do you have itchiness or stuffiness in the ear? Y N
 Do you hear ringing, buzzing, or hissing sounds in either ear? Y N

ROM

	MX OP W/ PAIN	W/ OUT PAIN
R LAT	L LAT	PROTRUS

BREATHING

Do you have allergies? Y N
 Do you have sinus problems? Y N
 Do you snore at night? Y N

Is your nose stuffed when you don't have a cold? Y N
 Have you been diagnosed with Sleep Apnea? Y N
 Have you had a sleep study done at a Sleep Clinic (hospitals)? Y N

I authorize the release of a full report of examination findings diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I authorize and consent to photographs, computer diagnostics, audio/video recordings and x-rays of the procedures to be performed for medical, dental or scientific studies. I understand that this information may be used in educational, informative or public presentations unless otherwise requested in writing prior to collection. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage. I understand that I may revoke this permission in writing at any time.

Patient Signature: _____ Date: _____

Facility Name: _____ updated 6-11-10