TMJ AND SLEEP QUESTIONNAIRE (B)

PATIENT NAME: ______________________________

BIRTH DATE: ______________ **AGE:** ______ **TODAY'S DATE:** ______________

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU ARE SEEKING TREATMENT IN OUR OFFICE?
NOTE: PLEASE IDENTIFY YOUR CHIEF COMPLAINT AS #1, LIST ALL OTHER SYMPTOMS IN PRIORITY #2-#9.

TMJ

	Recent	*Chronic (6 mo. +)*
_____Head pain	❍	❍
_____Ear pain	❍	❍
_____Jaw pain	❍	❍
_____Pain when chewing	❍	❍
_____Facial pain	❍	❍
_____Eye pain	❍	❍
_____Throat pain	❍	❍
_____Neck pain	❍	❍
_____Shoulder pain	❍	❍
_____Back pain	❍	❍
_____Limited ability to open mouth	❍	❍
_____Jaw joint locking	❍	❍
_____Jaw joint noises	❍	❍
_____Ear congestion	❍	❍
_____Sinus congestion	❍	❍
_____Dizziness	❍	❍
_____Tinnitus (ringing in the ears)	❍	❍
_____Muscle twitching	❍	❍
_____Vision problems	❍	❍

Sleep

	Recent	*Chronic (6 mo. +)*
_____Kicking or jerking leg repeatedly	❍	❍
_____Swelling in ankles or feet	❍	❍
_____Morning hoarseness	❍	❍
_____Dry mouth upon waking	❍	❍
_____Fatigue	❍	❍
_____Difficulty falling asleep	❍	❍
_____Tossing and turning frequently	❍	❍
_____Repeated awakening	❍	❍
_____Feeling unrefreshed in the morning	❍	❍
_____Significant daytime drowsiness	❍	❍
_____Frequent heavy snoring	❍	❍
_____Waking up from gasping	❍	❍
_____Told you stop breathing during sleep	❍	❍
_____Nighttime choking spells	❍	❍
_____Unable to tolerate C-Pap	❍	❍
_____Teeth grinding	❍	❍
_____Teeth crowding	❍	❍
_____Other______________	❍	❍

Do you have concerns in any of these areas: ❍ General Appearance ❍ Overbite ❍ Ability to function ❍ Smile

Other comments: ______________________________

Do any of the above complaints or concerns affect your daily life? ______________________________

Previous treatments/medications for the condition we are evaluating: ______________________________

What are the results you are seeking from treatment? ______________________________

Continues next page

CURRENT SYMPTOMS

HEAD PAIN

Location (*L=Left R=Right B+Bilateral*)	*Recent*	*Chronic* (*Over 6 mo.*)	*Severity*			*Duration*			*Frequency*		
			Mild	*Moderate*	*Severe*	*Minutes*	*Hours*	*Days*	*Occasional*	*Frequent*	*Constant*
L ❍ R ❍ B ❍ Frontal (Forehead)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
L ❍ R ❍ B ❍ Generalized	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
L ❍ R ❍ B ❍ Parietal (Top of head)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
L ❍ R ❍ B ❍ Occipital (Back of head)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
L ❍ R ❍ B ❍ Temporal (Temple area)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

Do you have pain or discomfort in any of the following areas? If so, please indicate the approximate date the pain began.

JAW PAIN
L ❍ R ❍ Jaw pain with opening
L ❍ R ❍ Jaw pain when chewing
L ❍ R ❍ Jaw pain at rest

JAW LOCKING
L ❍ R ❍ Jaw locks closed
L ❍ R ❍ Jaw locks open

EYE RELATED CONDITIONS
Yes ❍ No ❍ Blurred vision
Yes ❍ No ❍ Double vision
Yes ❍ No ❍ Eye pain
Yes ❍ No ❍ Pain or pressure behind the eyes
Yes ❍ No ❍ Extreme sensitivity to light (photophobia)
Yes ❍ No ❍ Wear glasses or contact lenses

THROAT RELATED CONDITIONS
Yes ❍ No ❍ Chronic sore throat
Yes ❍ No ❍ Difficulty swallowing
Yes ❍ No ❍ Swollen glands
Yes ❍ No ❍ Thyroid enlargement
Yes ❍ No ❍ Tightness in throat
Yes ❍ No ❍ Constant feeling of a foreign object in throat

SHOULDER RELATED CONDITIONS
Yes ❍ No ❍ Shoulder pain
Yes ❍ No ❍ Shoulder stiffness
Yes ❍ No ❍ Tingling in hands or fingers

BACK RELATED CONDITIONS
Yes ❍ No ❍ Back pain — lower
Yes ❍ No ❍ Back pain — middle
Yes ❍ No ❍ Back pain — upper
Yes ❍ No ❍ Sciatica
Yes ❍ No ❍ Scoliosis

MOUTH AND NOSE RELATED CONDITIONS
Yes ❍ No ❍ Dry mouth
Yes ❍ No ❍ Chronic sinusitis
Yes ❍ No ❍ Frequent snoring
Yes ❍ No ❍ Burning tongue
Yes ❍ No ❍ Broken teeth
Yes ❍ No ❍ Frequent biting of the cheek

JAW JOINT SOUNDS
L ❍ R ❍ Jaw sounds with opening
L ❍ R ❍ Jaw sounds when chewing
L ❍ R ❍ Jaw sounds at rest

JAW JOINT SYMPTOMS
Yes ❍ No ❍ Teeth clenching ❍ Day ❍ Night
Yes ❍ No ❍ Teeth grinding ❍ Day ❍ Night

EAR RELATED CONDITIONS
Yes ❍ No ❍ Buzzing in the ears
Yes ❍ No ❍ Ear congestion
Yes ❍ No ❍ Ear pain
Yes ❍ No ❍ Hearing loss
Yes ❍ No ❍ Itchiness or stuffiness in ears
Yes ❍ No ❍ Pain behind the ear
Yes ❍ No ❍ Pain in front of the ear
Yes ❍ No ❍ Recurrent ear infections
Yes ❍ No ❍ Ringing in the ear (Tinnitus)

NECK RELATED CONDITIONS
Yes ❍ No ❍ Limited movement of neck
Yes ❍ No ❍ Neck pain
Yes ❍ No ❍ Numbness in hands or fingers
Yes ❍ No ❍ Swelling in the neck

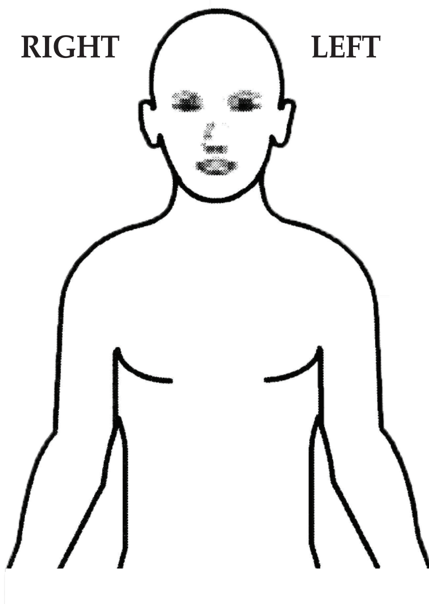
SLEEP CONDITIONS
Please select Yes or No answers based on your average sleep experience and/or what a sleep partner has told you.

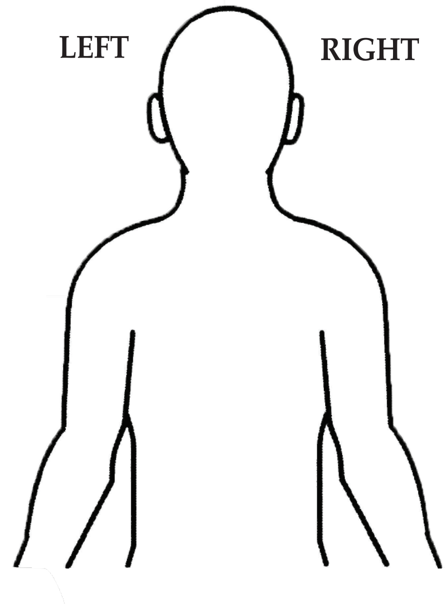
Sleep positions: ❍ Side ❍ Back ❍ Stomach
Average hours of sleep? ________
Is it easy to fall asleep? Yes ❍ No ❍
Do you wake often during the night? Yes ❍ No ❍
Do you feel rested upon AM waking? Yes ❍ No ❍
Do you gasp or choke during sleep? Yes ❍ No ❍
Do you stop breathing during sleep? Yes ❍ No ❍
Have you ever had a Sleep Sudy (PSG)? Yes ❍ No ❍
What were the results of your Sleep Study?____________________

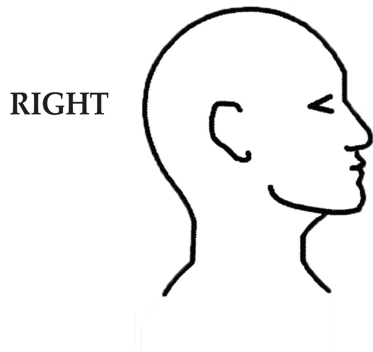
HISTORY OF SYMPTOMS
Approx what date did this condition or symptom(s) first occur?___________
Does any family member have the same or similar problem? Yes ❍ No ❍
If yes, please explain:____
Can you relate your pain or condition to a motor vehicle accident or traumatic injury? Yes ❍ No ❍

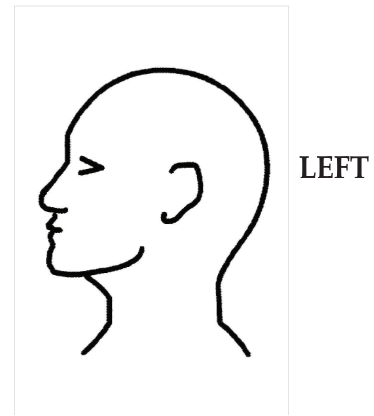
Continues next page

PLEASE INDICATE AREAS OF PAIN FOLLOWING THE PAIN SCALE:
1 = MILD PAIN • 2=MODERATE PAIN • 3=SEVERE PAIN









Continues next page

DAYTIME SLEEPINESS EVALUATION
Epworth Sleepiness Scale

The Epworth Sleepiness Scale was developed and validated by Dr. Murray Johns of Melbourne, Australia. It is a simple, self-administered questionnaire that is widely used by sleep professionals in quantifying the level of daytime sleepiness.

For the following situations, please 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 NAME: ______________________ **TODAY'S DATE:** ______________

Continues next page

NIGHTTIME SLEEPINESS EVALUATION
Screening Tool for Sleep Apnea

Developed by David White, M.D., Harvard Medical School, Boston, MA

Please answer the following questions.

			SCORE
1. Snoring			
a) Do you snore on most nights (>3 nights per week)?	Yes (2)	No (0)	______
b) Is your snoring loud? Can it be heard through a door or wall?	Yes (2)	No (0)	______
2. Has it ever been reported to you that you stop breathing or gasp during sleep?			
Never (0)	Occasionally (3)	Frequently (5)	______
3. What is your collar size?			
Male:	Less than 17" (0)	More than 17 inches (5)	______
Female:	Less than 16" (0)	More than 16 inches (5)	______
4. Do you occasionally fall asleep during the day when:			
a) You are busy or active?	Yes (2)	No (0)	______
b) You are driving or stopped at a light?	Yes (2)	No (0)	______
5. Have you had or are you being treated for high blood pressure?			
Yes (2)	No (0)		______
		TOTAL	______

____
Patient name

______________________________ ______________________________
Patient/Parent/Guardian Signature Date

Continues next page

AUTHORIZATION TO RELEASE OR REQUEST INFORMATION

I, ____ authorize **Boris Kaltchev, DMD**, **Boris Kaltchev, DMD, P.C.**, and/or **BK Dental, LLC**, to release or request information and communicate with the providers listed below including a full report of examination findings, diagnosis, photos, x-rays, treatment plan, and progress reports. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims.

DOCTOR'S NAME	LOCATION / PHONE

______________________________ Signature

______________________________ Date