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? ____________________

____

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CURRENT SYMPTOMS

HEAD PAIN

Location (L=Left R=Right B+Bilateral)	Recent	Chronic (Over 6 mo.)	Severity: Mild	Severity: Moderate	Severity: Severe	Duration: Minutes	Duration: Hours	Duration: Days	Frequency: Occasional	Frequency: Frequent	Frequency: 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 ❍

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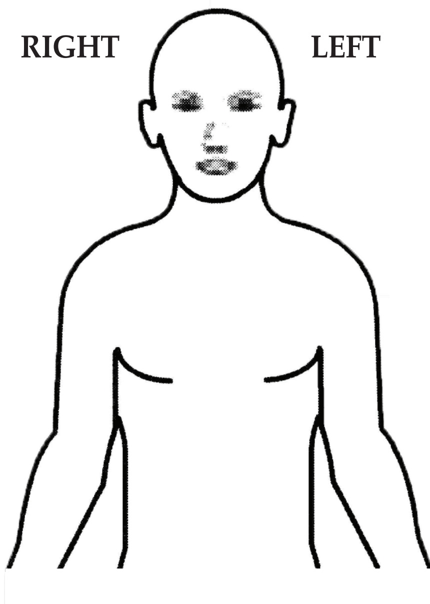
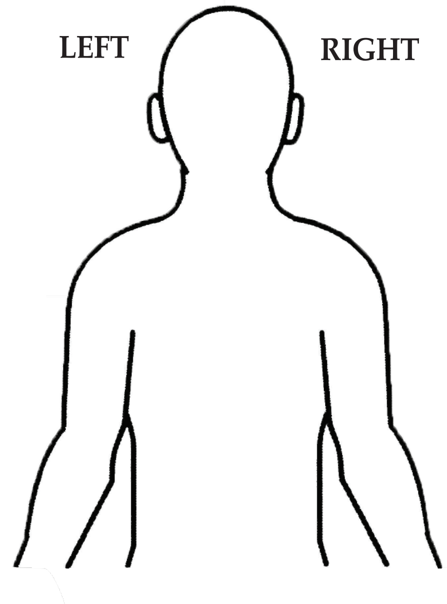
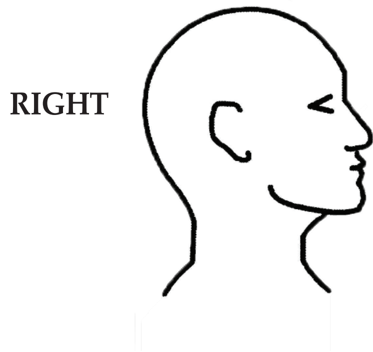
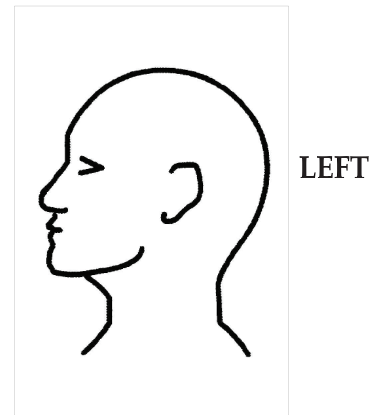
BK DENTAL
Boris Kaltchev DMD

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









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