SUMMIT DENTAL
of La Mesa

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This questionnaire was designed to provide important facts regarding the history of your Craniofacial pain or sleep condition. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible.

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

- ❑ Jaw pain
- ❑ Facial pain
- ❑ Pain when chewing
- ❑ Jaw clicking/popping
- ❑ Jaw locking
- ❑ Jaw joint noises (crepitus or grinding)
- ❑ Limited mouth opening
- ❑ Eye pain
- ❑ Ear pain
- ❑ Neck pain
- ❑ Throat Pain
- ❑ Difficulty Swallowing
- ❑ Back pain
- ❑ Shoulder pain
- ❑ Morning headaches
- ❑ Headaches
- ❑ Migraines
- ❑ Ringing in the ears
- ❑ Dizziness
- ❑ Nocturnal teeth clinching or grinding
- ❑ Daytime clenching or grinding
- ❑ Frequent heavy snoring
- ❑ Snoring that affects the sleep of others
- ❑ Sleep apnea
- ❑ CPAP intolerance
- ❑ Feeling un-refreshed in the morning
- ❑ Significant daytime drowsiness
- ❑ Difficulty falling asleep
- ❑ I have been told that "I stop breathing" when sleeping
- ❑ Gasping when waking up
- ❑ Nighttime choking spells
- ❑ Morning hoarseness
- ❑ Swelling in ankles or feet
- ❑ Other: _____

History of Treatment

Practitioner's Name	Specialty	Treatment	Approximate Date

Patient Name:_____

Date of Initial Screening:_____/_____/_____ Date of Comprehensive Exam:_____/_____/_____

SYMPTOMS *(L=Left R=Right B=Both sides)*

Head Pain **Location**	**Severity**			**Frequency**			**Duration**				
	Mild	Moderate	Severe	Occasional	Frequent	Constant	Seconds	Minutes	Hours	Days	Weeks
L R B Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Entire head (Generalized) L	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
R B Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Monthly or less / Weekly / Every Day

Jaw Symptoms

Y☐ N☐ Jaw clicks
Y☐ N☐ Jaw locks closed
Y☐ N☐ Jaw locks open
Y☐ N☐ Jaw popping
Y☐ N☐ Teeth clenching
Y☐ N☐ Teeth grinding

Eye Related Conditions

Y☐ N☐ Blurred vision
Y☐ N☐ Double vision
Y☐ N☐ Eye pain
Y☐ N☐ Pain or pressure behind the eyes
Y☐ N☐ Photophobia (extreme sensitivity to light)

Ear Related Conditions

Y☐ N☐ Buzzing in the ears
Y☐ N☐ Ear congestion
Y☐ N☐ Ear pain
Y☐ N☐ Hearing loss
Y☐ N☐ Pain behind ear
Y☐ N☐ Pain in front of ear
Y☐ N☐ Recurrent ear infections
Y☐ N☐ Tinnitus (ringing)

Lifestyle Related Conditions

Y☐ N☐ Currently under unusual stress
Y☐ N☐ Recent change in lifestyle
Y☐ N☐ Recent change in work pattern
Y☐ N☐ Drink 4 or more cups of coffee per day
Y☐ N☐ Smoke tobacco
Y☐ N☐ Chew tobacco

Jaw Pain

L R B Jaw pain – on opening
L R B Jaw pain – while chewing
L R B Jaw pain – at rest

Throat, Neck, & Back Related Conditions

Y☐ N☐ Back pain-lower
Y☐ N☐ Back pain-middle
Y☐ N☐ Back pain-upper
Y☐ N☐ Chronic sore throat
Y☐ N☐ Constant feeling of a foreign object in throat
Y☐ N☐ Difficulty in swallowing
Y☐ N☐ Limited movement of neck
Y☐ N☐ Neck pain
Y☐ N☐ Numbness in the hands
Y☐ N☐ Sciatica
Y☐ N☐ Scoliosis
Y☐ N☐ Shoulder pain
Y☐ N☐ Shoulder stiffness
Y☐ N☐ Swelling in the neck
Y☐ N☐ Swollen glands
Y☐ N☐ Thyroid enlargement
Y☐ N☐ Tightness in throat
Y☐ N☐ Tingling in the hands or fingers

Mouth & Nose Related Conditions

Y☐ N☐ Broken teeth
Y☐ N☐ Burning tongue
Y☐ N☐ Chronic sinusitis
Y☐ N☐ Dry mouth
Y☐ N☐ Frequent snoring
Y☐ N☐ Frequent biting of cheek

Does any family member have the same or similar problem? Y☐ N☐
If YES, please explain: _____

What makes your discomfort/symptoms worse? _____
Is there anything else our doctors should know regarding your health? _____

Pain Description

- ❑ Sharp, stabbing or burning
- ❑ Throbbing or pulsating
- ❑ Dull & aching
- ❑ Constant
- ❑ Episodic (Not Constant)
- ❑ Radiating
- ❑ Mild Pain
- ❑ Moderate Pain
- ❑ Severe Pain

History of Symptoms

Is there anything that makes you pain or discomfort better? _____

_____

When did symptoms first start? _____

When having pain do you experience: ❑ N/A

- ❑ Dizziness
- ❑ Double vision
- ❑ Fatigue
- ❑ Nausea
- ❑ Sensitivity to light (photophobia)
- ❑ Sensitivity to noise
- ❑ Throbbing
- ❑ Vomiting
- ❑ Burning
- ❑ Other: _____

History of Accident or Related Incident

What do you believe is the cause of the pain or condition to be?

- ❑ A motor vehicle accident
- ❑ A motorcycle accident
- ❑ A work related incident
- ❑ A playground incident
- ❑ An athletic endeavor
- ❑ A fight
- ❑ A fall
- ❑ An accident
- ❑ Hit by an object
- ❑ Hit an object
- ❑ An illness
- ❑ An injury
- ❑ Orthodontics
- ❑ Dental procedures
- ❑ Whiplash
- ❑ Stress
- ❑ Unknown
- ❑ Other:_____

Date of Accident or Related Incident (month/day/year):_____ ❑ N/A

If your pain or condition is related to an accident were you (please select one): ❑ N/A

- ❑ A passenger in a motor vehicle?
- ❑ The driver of a vehicle?
- ❑ A pedestrian?
- ❑ At work?
- ❑ Other:

❑ Yes ❑ No Did you fall?
❑ Yes ❑ No Were you hit by an object?

If yes, what was the object? _____

❑ Yes ❑ No Did you hit an object?

If yes, what was the object? _____

Please indicate location below if there was any trauma. ❑ N/A

- ❑ Forehead
- ❑ Face
- ❑ Chin
- ❑ Side of head
- ❑ Back of head
- ❑ Top of head
- ❑ Teeth
- ❑ Jaw
- ❑ Other: _____

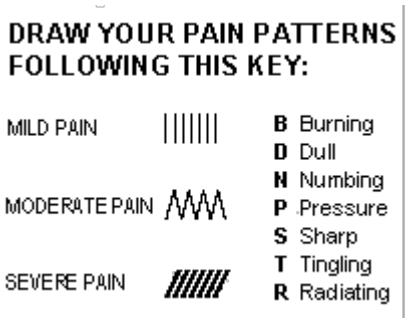
If you were in a vehicle accident, where was the vehicle hit? ❑ N/A

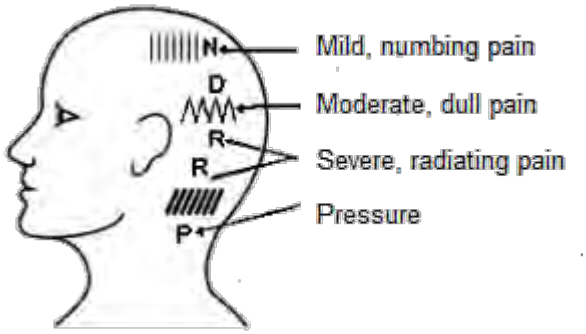
- ❑ At the front end
- ❑ At the rear end
- ❑ At the front right area
- ❑ At the front left area
- ❑ At the rear right area
- ❑ At the rear left area
- ❑ Head on
- ❑ On the driver's side
- ❑ On the passenger's side
- ❑ Other area: _____

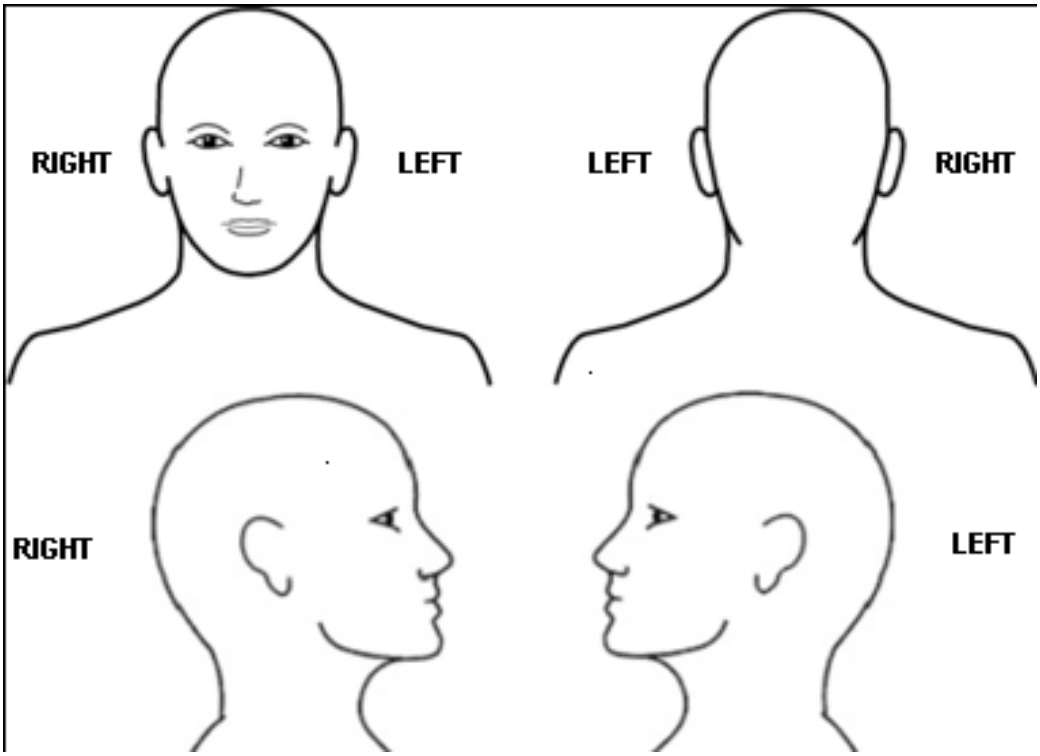
Did you forcible strike the: ❑ N/A

- ❑ Steering wheel
- ❑ Windshield
- ❑ Passenger's side window
- ❑ Driver's side window
- ❑ Passenger's side door
- ❑ Driver's side door
- ❑ Headrest
- ❑ Seat
- ❑ Roof
- ❑ Interior of the car
- ❑ Other: _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY







Name:_____ **Height:**_____ **Weight:**_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	**Chance of Dozing**
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theater or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____
Total Score	_____

Have you ever been diagnosed with:	**Yes**	**No**
1. Impaired Cognition (i.e. difficulty concentrating or thinking)	❑	❑
2. Mood Disorders/Depression	❑	❑
3. Insomnia	❑	❑
4. Hypertension (high blood pressure)	❑	❑
5. Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	❑	❑
6. History of Stroke	❑	❑
7. Sleep Apnea	❑	❑
If yes: Did you try to use CPAP	❑	❑
8. TMJ problems significant enough to require treatment	❑	❑
9. Gastric Reflux (GERD) or Heartburn	❑	❑

Are you aware of (or have you been told):	**Yes**	**No**
1. Snoring on a regular basis	❑	❑
2. Feeling tired or fatigued on a regular basis	❑	❑
3. Clenching or grinding your teeth (bruxism)	❑	❑
4. Having frequent headaches	❑	❑
5. Your neck size being > 17 inches (male) or > 16 inches (female)	❑	❑
6. Anyone in your family having sleep apnea	❑	❑
7. Stopping breathing when sleeping/awakening with a gasp	❑	❑

Do you weigh more for your height than is shown in the table below? ❑ ❑

Height	Weight (lb)		Height	Weight (lb)		Height	Weight (lb)		Height	Weight (lb)
4’10”	167		5’3”	197		5’8”	230		6’1”	265
4’11”	173		5’4”	204		5’9”	237		6’2”	272
5’	179		5’5”	210		5’10”	243		6’3”	279
5’1”	185		5’6”	216		5’11”	250		6’4”	287
5’2”	191		5’7”	223		6’	258		6’5”	295

Weights shown in the tables above correspond to BMI of 35 for a given height.

For children only (filled out by parent or guardian)

Are you aware of your child:	**Yes**	**No**
1. Snoring/noisy breathing while sleeping	❑	❑
2. Grinding his or her teeth	❑	❑
3. Wetting the bed	❑	❑
4. Having difficulty in school/learning	❑	❑
5. Being treated for ADD or ADHD	❑	❑
6. Breathing primarily through their mouth	❑	❑
7. Having frequent nightmares/night terrors	❑	❑
8. Having frequent ear aches	❑	❑

Dental Exam Findings:

❑ **Evidence of Bruxism**
❑ **Tori or Bone Loss**
❑ **Mallampati 3 or 4**
❑ **Scalloping of the tongue**
❑ **Anterior wear**
❑ **Vaulted Palate**
❑ **Crowded airway**
❑ **Retrognathia / Class II**
❑ **Narrow Upper Arch**

SLEEP CENTER EVALUATION

Have you ever had an evaluation at a Sleep Center? ❑ Yes ❑ No

Sleep Center Name:_____ Location:_____Date of Study: _____

CPAP (Continuous Positive Airway Pressure device)

Have you used CPAP? ❑ Yes ❑ No For how long: _____

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to (mark all that apply):

- ❑ Mask leaks
- ❑ I was unable to get the mask to fit properly
- ❑ Discomfort caused by the strap or headgear
- ❑ Disturbed or interrupted sleep caused by the presence of the device
- ❑ Noise from the device disturbing my and/or bed partner's sleep
- ❑ CPAP restricted movements during sleep
- ❑ CPAP does not seem to be effective
- ❑ Pressure on the upper lip causing tooth related problems
- ❑ A latex allergy
- ❑ Claustrophobic associations
- ❑ An unconscious need to remove the CPAP apparatus at night
- ❑ Other: _____

OTHER THERAPY ATTEMPTS (What other therapies have you had for breathing disorders?) ❑ N/A

- ❑ None
- ❑ Dieting
- ❑ Weight loss
- ❑ CPAP
- ❑ BiPAP
- ❑ AutoPAP
- ❑ Nasal Strips
- ❑ Pillar Implant Procedure
- ❑ Positional Therapy (Side Sleeping)
- ❑ Previous Oral Appliance Therapy
- ❑ Smoking Cessation
- ❑ Surgery (Adenoids and Tonsils)
- ❑ Surgery (Laser Assisted Uvulopalatoplasty)
- ❑ Surgery (Uvulopalatopharyngoplasty - UPPP)
- ❑ Surgery (Bariatric)
- ❑ Surgery (Jaw Reconstruction)
- ❑ Surgery (Muscle Reattachment)
- ❑ Surgery (Tongue Reduction

Has any doctor recommended that you have surgery for this condition? ❑ Yes ❑ No

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature:_____ Date: _____

I certify that the medical history information is complete and accurate.

Patient Signature:_____ Date: _____