TMJ & Sleep Therapy Centre of North Central Florida

Comprehensive Health Questionnaire

Patient Information

☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr.

First Name: _____ Middle Initial: ____ Last Name: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Referred by: _____ ☐DDS ☐MD ☐DO ☐DC ☐Other _____

Address and/or Phone Number of Healthcare Provider: _____

Patient Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Alternate Contact Number: _____

Email: _____

Type of Employment: _____ Place of Employment: _____

Responsible Party (if different than patient): _____

Address: _____ City:_____ State: _____ Zip:_____

Family Physician: _____ Phone Number: _____

Family Dentist: _____ Phone Number: _____

What is your chief concern and reason for this visit: _____

What are the results you are seeking from treatment: _____

_____

Do you currently experience any of the following symptoms?

Please number your chief complaints 1-4

	Recent	Chronic
____ Headache (inside your head)	☐	☐
____ Headache (outside your head)	☐	☐
____ Jaw Pain	☐	☐
____ Chewing Pain	☐	☐
____ Face Pain	☐	☐
____ Eye Pain	☐	☐
____ Throat Pain	☐	☐
____ Neck Pain	☐	☐
____ Shoulder Pain	☐	☐
____ Back Pain	☐	☐
____ Dyskinesia	☐	☐
____ Difficulty Opening Mouth	☐	☐
____ Difficulty Closing Mouth	☐	☐
____ Noises in Jaw Joints	☐	☐
____ Ear Stuffiness	☐	☐
____ Dizziness	☐	☐
____ Ringing in Ears (Tinnitis)	☐	☐
____ Vision Problems	☐	☐
____ Muscle Spasm	☐	☐
____ Sinus Congestion	☐	☐
____ Kicking or jerking leg repeatedly	☐	☐
____ Swelling in ankles or feet	☐	☐
____ Numbness (Localized)	☐	☐
____ Nerve Pain	☐	☐
____ Dental Changes	☐	☐
____ Teeth Spacing	☐	☐
____ Teeth Sensitivity	☐	☐
____ Changes with your Bite	☐	☐
____ Any Other Symptoms not listed above _____		

	Recent	Chronic
____ Morning Hoarseness	☐	☐
____ Dry Mouth Upon Waking	☐	☐
____ Fatigue	☐	☐
____ Difficulty Falling Asleep	☐	☐
____ Tossing and Turning Frequently	☐	☐
____ Repeated Awakening	☐	☐
____ Feeling Un-refreshed in the Morning	☐	☐
____ Morning Headaches	☐	☐
____ Nighttime Urination	☐	☐
____ Night Sweats	☐	☐
____ Vivid Dreams	☐	☐
____ Sore Jaw Upon Waking	☐	☐
____ Significant Daytime Drowsiness	☐	☐
____ Affect Sleep of Others	☐	☐
____ Short of Breath when Waking	☐	☐
____ Told "I stop breathing" During Sleep	☐	☐
____ Night-Time Choking Spells	☐	☐
____ Unable to Tolerate C-Pap	☐	☐
____ Tooth Grinding	☐	☐
____ Teeth Crowding	☐	☐
____ Frequent Heavy Snoring	☐	☐
____ Acid Indigestion	☐	☐

Patient/Parent Signature: _____ Date: _____

TMJ & Sleep Therapy Centre of North Central Florida

Sleep Conditions - Please select the yes or no answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Position? ☐Side ☐Back ☐Stomach ☐Varies
Sleep Location? ☐Bed ☐Couch ☐Chair ☐Other
Bed Partner? ☐Yes ☐No
Average hours of sleep per night? _____
Is it easy to fall asleep? ☐Yes ☐No
Average hours of sleep per day? _____
Do you wake often during the night? ☐Yes ☐No
Cough, gasps or snorts on waking? ☐Yes ☐No
Do you feel rested upon waking? ☐Yes ☐No
Observed pauses in breath? ☐Yes ☐No
Stopped breathing during sleep? ☐Yes ☐No
Have you ever had a Sleep Study? ☐HST ☐PSG ☐No Date: _____ Result: _____
Previous Positive Airway Pressure Devices Used? ☐CPAP ☐BiPAP ☐ASV ☐APAP
Do you currently use a PAP Device? ☐Yes ☐No Type: _____
Previous Oral Appliance? ☐Yes ☐No Type: _____

Allergic Reactions

Please check any and all medications or substance that have caused an allergic reaction

☐ Anesthetics ☐ Antibiotics ☐ Aspirin
☐ Barbiturates ☐ Codeine ☐ Iodine
☐ Latex ☐ Metals ☐ Plastics
☐ Penicillin ☐ Sedatives ☐ Sulfa
☐ Food Allergies/Sensitivities _____
Other: _____

Current Medications

Please list all medications and supplements (over-the-counter and prescription) you are taking and the reason you take them.

Medication	Dosage	Reason for Taking

☐ See attached list

Previous Treatment, Medications and Other Therapies Attempted For The Condition We Are Evaluating

Treatment/Med/Therapy	Doctor/Provider	Approx. Date of Tx	Helpful (y/n)

☐ See attached list

Health And Medical History

Are you currently pregnant? ☐ Yes ☐No
Do you drink 4 or more cups of coffee per day? ☐ Yes ☐No
Do you smoke tobacco? ☐ Yes ☐No
Do you consume alcohol or take sedatives? ☐ Yes ☐No
Do you have trouble breathing through your nose? ☐ Yes ☐No
Have you had prior orthodontic treatments? ☐ Yes ☐No
Have you sustained injury to: ☐ Head ☐ Neck ☐ Face ☐Teeth
☐ Other: _____

Surgical History - *Have you had any of the following:*

General Anesthesia ☐ Yes ☐No
Adenoids Removed ☐ Yes ☐No
Tonsils Removed ☐ Yes ☐No
Jaw Joint Surgery ☐ Yes ☐No
Orthognathic Surgery ☐ Yes ☐No
Oral Surgery ☐ Yes ☐No
Removal of Third Molar (Wisdom Teeth) ☐ Yes ☐No

Other types of surgery:
_____
_____

Patient/Parent Signature: _____ Date: _____

TMJ & Sleep Therapy Centre of North Central Florida

Additional Health And Medical History

Do you have or have you experienced any of the following

Anemia	☐ Yes	☐No ☐Fam Hx
Anxiety	☐ Yes	☐No ☐Fam Hx
Asthma	☐ Yes	☐No ☐Fam Hx
Bleeding Easily	☐ Yes	☐No ☐Fam Hx
Birth Defects	☐ Yes	☐No ☐Fam Hx
Bruising Easily	☐ Yes	☐No ☐Fam Hx
Cancer of _____	☐ Yes	☐No ☐Fam Hx
Chemo	☐ Yes	☐No ☐Fam Hx
Chronic Fatigue	☐ Yes	☐No ☐Fam Hx
Cold Hands and Feet	☐ Yes	☐No ☐Fam Hx
COPD	**☐ Yes**	**☐ No ☐ Fam Hx**
Depression	**☐ Yes**	**☐ No ☐ Fam Hx**
Diabetes	**☐ Yes**	**☐ No ☐ Fam Hx**
Difficulty Concentrating	☐ Yes	☐No ☐Fam Hx
Difficulty Breathing at Night	☐ Yes	☐No ☐Fam Hx
Dizziness	☐ Yes	☐No ☐Fam Hx
Emphysema	☐ Yes	☐No ☐Fam Hx
Epilepsy	☐ Yes	☐No ☐Fam Hx
Excessive Thirst	☐ Yes	☐No ☐Fam Hx
Fainting	☐ Yes	☐No ☐Fam Hx
Fibromyalgia	☐ Yes	☐No ☐Fam Hx
Fluid Retention	☐ Yes	☐No ☐Fam Hx
Frequent Colds/Flu	☐ Yes	☐No ☐Fam Hx
Frequent Cough	☐ Yes	☐No ☐Fam Hx
Frequent Ear Infections	☐ Yes	☐No ☐Fam Hx
Frequent Sore Throat	☐ Yes	☐No ☐Fam Hx
Awakening from Sleep ____ x	☐ Yes	☐No ☐Fam Hx
Gastroesophogeal Reflux	☐ Yes	☐No ☐Fam Hx
Glaucoma	☐ Yes	☐No ☐Fam Hx
Hay Fever	☐ Yes	☐No ☐Fam Hx
Hearing Impairment	☐ Yes	☐No ☐Fam Hx
Heart Attack	☐ Yes	☐No ☐Fam Hx
Heart Disease	**☐ Yes**	**☐ No ☐ Fam Hx**
Heart Murmur	☐ Yes	☐No ☐Fam Hx
Heart Pacemaker	☐ Yes	☐No ☐Fam Hx
Heart Palpitations	☐ Yes	☐No ☐Fam Hx
Heart Valve Replacement	☐ Yes	☐No ☐Fam Hx
Hemophilia	☐ Yes	☐No ☐Fam Hx
Hepatitis	☐ Yes	☐No ☐Fam Hx
High Blood Pressure	**☐ Yes**	**☐ No ☐ Fam Hx**
History of Substance Abuse	☐ Yes	☐No ☐Fam Hx
Huntington's Disease	☐ Yes	☐No ☐Fam Hx
Hypoglycemia	☐ Yes	☐No ☐Fam Hx
Insomnia	**☐ Yes**	**☐ No ☐ Fam Hx**
Intestinal Disorder	☐ Yes	☐No ☐Fam Hx
Irregular Heartbeat	☐ Yes	☐No ☐Fam Hx
Kidney Disease	☐ Yes	☐No ☐Fam Hx
Leukemia	☐ Yes	☐No ☐Fam Hx
Liver Disease	☐ Yes	☐No ☐Fam Hx
Low Blood Pressure	☐ Yes	☐No ☐Fam Hx
Meniere's Disease	☐ Yes	☐No ☐Fam Hx
Memory Loss	☐ Yes	☐No ☐Fam Hx
Migraines	☐ Yes	☐No ☐Fam Hx
Mitral Valve Prolaps	☐ Yes	☐No ☐Fam Hx
Multiple Sclerosis	☐ Yes	☐No ☐Fam Hx
Muscle Aches	☐ Yes	☐No ☐Fam Hx
Muscle Fatigue	☐ Yes	☐No ☐Fam Hx
Muscle Spasms	☐ Yes	☐No ☐Fam Hx
Muscular Dystrophy	☐ Yes	☐No ☐Fam Hx
Neuralgia	☐ Yes	☐No ☐Fam Hx
Nervous system Disorder	☐ Yes	☐No ☐Fam Hx
Osteoarthritis	☐ Yes	☐No ☐Fam Hx
Osteoporosis	☐ Yes	☐No ☐Fam Hx
Ovarian Cyst	☐ Yes	☐No ☐Fam Hx
Parkinson's Disease	☐ Yes	☐No ☐Fam Hx
Poor Circulation	☐ Yes	☐No ☐Fam Hx
Psychiatric Care	☐ Yes	☐No ☐Fam Hx
Radiation	☐ Yes	☐No ☐Fam Hx
Recent Weight Gain	☐ Yes	☐No ☐Fam Hx
Recent Weight Loss	☐ Yes	☐No ☐Fam Hx
Rheumatic Fever	☐ Yes	☐No ☐Fam Hx
Rheumatoid Arthritis	☐ Yes	☐No ☐Fam Hx
Scarlet Fever	☐ Yes	☐No ☐Fam Hx
Shortness of Breath	☐ Yes	☐No ☐Fam Hx
Skin Disorder	☐ Yes	☐No ☐Fam Hx
Sinus Problems	☐ Yes	☐No ☐Fam Hx
Slow Healing Sores	☐ Yes	☐No ☐Fam Hx
Speech Difficulties	☐ Yes	☐No ☐Fam Hx
Stroke	**☐ Yes**	**☐ No ☐ Fam Hx**
Swollen or Painful Joints	☐ Yes	☐No ☐Fam Hx
Thyroid Disease	**☐ Yes**	**☐ No ☐ Fam Hx**
Tired Muscles	☐ Yes	☐No ☐Fam Hx
Tuberculosis	☐ Yes	☐No ☐Fam Hx
Urinary Tract Disorder	☐ Yes	☐No ☐Fam Hx

Patient/Parent Signature: _____ Date: _____

TMJ & Sleep Therapy Centre of North Central Florida

Additional Symptoms

Head Pain

	Location (L = Left R = Right B = Bilateral)	*Recent*	*Chronic* (over 6mo.)	*Severity* Mild Mod Severe	*Duration* Hrs Days Wks	*Frequency* Occ. Freq Constant
Temple Area	☐L☐R☐B	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
Back of Head	☐L☐R☐B	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
Forehead	☐L☐R☐B	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
Top of Head	☐L☐R☐B	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
All of Head	☐L☐R☐B	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐

Jaw Pain

Jaw pain with opening ☐L ☐R
Jaw pain when chewing ☐L ☐R
Jaw pain at rest ☐L ☐R

Jaw Joint Sound

Jaw sounds with opening ☐L ☐R
Jaw sounds when chewing ☐L ☐R

Jaw Locking

Jaw locks closed ☐Yes ☐No
Jaw locks open ☐Yes ☐No

Jaw Joint Symptoms

Teeth clenching ☐Yes ☐No ☐Day ☐Night
Teeth grinding ☐Yes ☐No ☐Day ☐Night

Eye Related Conditions

Blurred vision ☐Yes ☐No
Double vision ☐Yes ☐No
Eye pain ☐Yes ☐No
Pain or pressure behind the eyes ☐Yes ☐No
Extreme sensitivity to light ☐Yes ☐No
Wear of glasses or contacts ☐Yes ☐No

Ear Related Conditions

Buzzing in ears ☐L ☐R
Ear Congestion ☐L ☐R
Ear pain ☐L ☐R
Hearing Loss ☐L ☐R
Itchiness/stuffiness ☐L ☐R
Pain behind the ear ☐L ☐R
Pain in front of ear ☐L ☐R
Recurrent ear infections ☐L ☐R
Ringing in the ear (tinnitus) ☐L ☐R

Throat Related Conditions

Chronic sore throat ☐Yes ☐No
Difficulty Swallowing ☐Yes ☐No
Swollen glands ☐Yes ☐No
Thyroid enlargement ☐Yes ☐No
Tightness in throat ☐Yes ☐No
Feeling of foreign object in throat ☐Yes ☐No

Neck related Conditions

Limited movement ☐Yes ☐No
Neck pain ☐Yes ☐No
Numbness in hands/fingers ☐Yes ☐No
Swelling in neck ☐Yes ☐No

Shoulder Conditions

Pain in Shoulder ☐Yes ☐No
Stiffness in Shoulder ☐Yes ☐No
Tingling in fingers/hands ☐Yes ☐No

Back Conditions

Low Back Pain ☐Yes ☐No
Middle Back Pain ☐Yes ☐No
Upper Back Pain ☐Yes ☐No
Scoliosis ☐Yes ☐No
Sciatica ☐Yes ☐No

Mouth/Nose Conditions

Chronis Sinusitis ☐Yes ☐No
Dry Mouth ☐Yes ☐No
Frequent Snoring ☐Yes ☐No
Broken Teeth ☐Yes ☐No
Biting Cheeks ☐Yes ☐No
Burning Tongue ☐Yes ☐No

Patient/Parent Signature: _____ Date: _____

History of Symptoms

On what date, or approximate date, did the condition you are seeking treatment for occur? _____

Are any of the conditions listed or was your chief complaint caused by a motor vehicle accident? ☐Yes ☐No

If yes, what conditions: _____ Date of accident: _____

Does any family member have a sleep breathing disorder? ☐Yes ☐No If yes, explain: _____

_____

_____

_____

Adult - Complete this section

1. DAYTIME SLEEPINESS EVLAUATION - EPWORTH SLEEPINESS SCALE

For the following situations, 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	Situation	Score
Sitting and reading	_____	Sitting and talking to someone	_____
Watching Television	_____	Sitting quietly after a lunch (no alcohol)	_____
Sitting, inactive public place	_____	In a car, while stopped for a few minutes in traffic	_____
As a passenger in a car for an hour without a break	_____	Lying down to rest in the afternoon when circumstances permit	_____
		TOTAL SCORE	_____

2. NIGHTTIME SLEEPINESS EVALUATION

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

1. Snoring — Score

   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 inches (0) More than 17 inches (5)

   Female: Less than 16 inches (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 _____

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, third party billing companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient/Parent Signature: _____ Date: _____

3. Child - Complete this section

BEARS SLEEP SCREENING ALGORITHM

The "BEARS" instrument is divided into five major sleep domains, providing a comprehensive screen for the major sleep disorders affecting children in the 2- to 18-year old range. Each sleep domain has a set of age-appropriate "trigger questions" for use in the clinical interview.

B = bedtime problems
E = excessive daytime sleepiness
A = awakenings during the night
R = regularity and duration of sleep
S = snoring

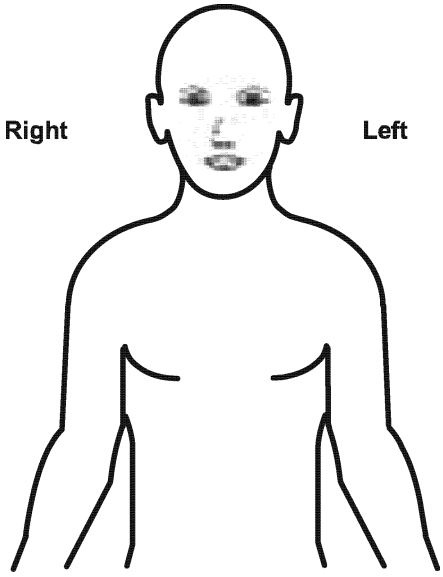
A parent answers questions in **black**, the subject child answers questions written in **blue**:

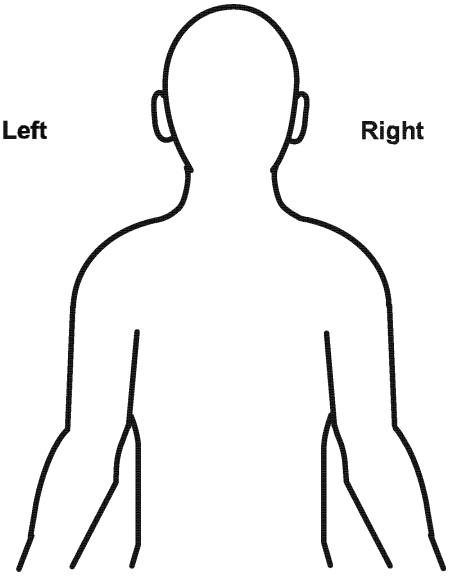
Symptom	Age Toddler/Preschool (2-5 years)	Age School Age (6-12 years)	Age Adolescent (13-18 years)
1. Bedtime Problems	Does your child have any problems going to bed? Y N	Does your child have any problems at bedtime? (P) Y N Do you have any problems going to bed? (C)	Do you have any problems falling asleep at bedtime? (C) Y N
2. Excessive Daytime Sleepiness	Does your child seem overtired or sleepy a lot during the day? Y N	Does your child have difficulty waking in the morning, seem sleepy during the day or take naps? (P) Y N Do you feel tired a lot? (C) Y N	Do you feel sleepy a lot during the day? Y N In School? Y N While Driving? (C) Y N
3. Awakenings during the night	Does your child wake up a lot at night? (P) Y N	Does your child seem to wake up a lot at night? Y N Any sleepwalking or nightmares? (P) Y N Do you wake up a lot at night? Y N Have trouble getting back to sleep? (C) Y N	Do you wake up a lot at night? Y N Have trouble getting back to sleep? (C) Y N
4. Regularity and duration of sleep	Does your child have a regular bedtime and wake time? Y N What are they? _____	What time does your child go to bed and get up on school days? _____ _____ Weekends? _____ Do you think he/she is getting enough sleep? (P) Y N	What time do you usually go to bed on school nights? _____ _____ Weekends? _____ How much sleep do you usually get? (C) _____
5. Snoring	Does your child snore a lot or have difficult breathing at night? Y N	Does your child have loud or nightly snoring or any breathing difficulties at night? (P) Y N	Does your teenager snore loudly or nightly? (P) Y N

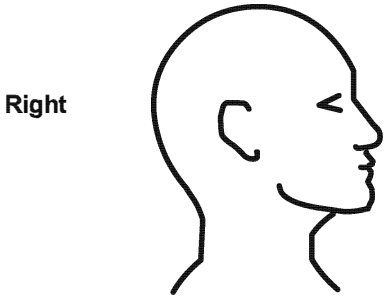
(P) Parent-directed question
(C) Child-directed question

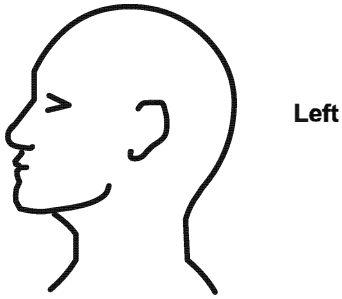
Source: "A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems" by Jodi A. Mindell and Judith A. Owens; Lippincott Williams & Wilkins

Patient/Parent Signature: _____ Date: _____









Indicate Areas of Pain
Following the Pain Scale:
1 Mild pain
2 Moderate pain
3 Severe pain

AUTHORIZATION TO RELEASE INFORMATION TO THE BELOW LISTED REFERRING AND TREATING HEALTH CARE PROFESSIONALS:

Doctors Name **Location/Phone**

_____

_____

_____

_____

_____

_____

_____

I authorize the release of communications regarding my treatment with _____ including a full report of examination findings, diagnosis, treatment plan, and progress reports to the providers listed above.

Signed _____ Date _____