

Facial Problem Questionnaire



General & Cosmetic Care

1500 Summer Street
Stamford, CT 06905

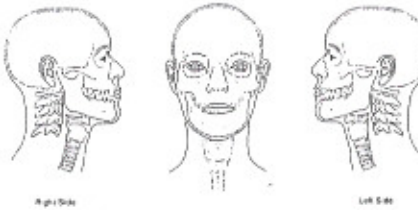
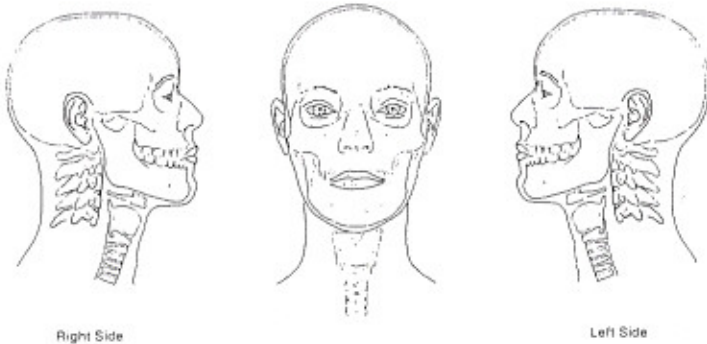
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Visit us on the web at
DentalCareStamford.com

I. Name _____ Age _____
Date _____ Referred by _____

II. Which of the following do you have (circle all that apply)
Headaches Neck Pain Jaw pain Ear Pain
Facial Pain Bite Problems Damaged teeth
Other _____

III. Please shade in where your pain is located:



Please do not write in this space.

Date _____

IV. How long have you had this pain? _____
Is the pain constant? _____
Is the pain (circle all that apply) Aching Burning
Stabbing Sharp Dull Other _____
Is the pain worse in the (circle all that apply)
Morning Afternoon Evening Night
What makes the pain better? _____

What makes the pain worse?

V. What medication do you take or have you previously taken for your pain?

MEDICATION	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please do not write in this space.

VI. Does it hurt to move your jaw? Y N
Does it hurt to chew? Y N
Any discomfort upon chewing hard foods like carrots? Y N
Do your jaw muscles get tired from chewing? Y N
Does it hurt to open wide? Y N
Which side of your jaw makes a popping sound? R L
Which side of your jaw makes a clicking noise? R L
Which side of your jaw makes other noises? R L
What Noises? _____
When did you first notice the noises? _____

VII. Have you ever not been able to open your jaw all the way? Y N
Have you ever had to wiggle your jaw to get it open? Y N
Has your jaw ever been stuck open and you could not close it? Y N
When did this first happen? _____
When did this last happen? _____

VIII. Have you noticed a change in the way your teeth come together? Y N
Have you noticed your teeth shifting? Y N
Has the shape of your face changed? Y N

IX. Are your teeth sore or sensitive? Y N
 Do you clench your teeth? Y N
 Do you grind your teeth? Y N
 Do you do this during the day or night? Day Night
 When did you start clenching or grinding? _____

X. Which of the following dental procedures have you had (please circle):
 Fillings Orthodontics Root Canal
 Crowns Bridges Bite Adjustment

If you had braces, how many times were you in braces? _____
 How old were you when you got braces? _____
 How old were you when you were done? _____

Have you ever had a tooth extracted? Y N
 Have you ever split or broken a tooth? Y N
 Do you feel there is any connection between the dental work you have had done and the problems you are having? Y N

XI. Have you ever injured or sustained any form of trauma or whiplash to your (circle all that apply) Jaw Head Neck
 None of the above

(If so please complete the trauma questionnaire)

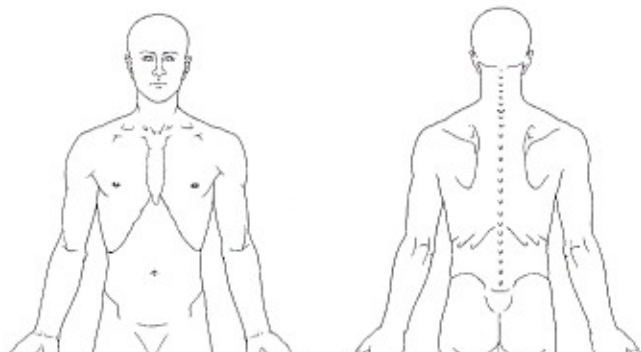
Do you feel there is any connection between the trauma you have had and the problems you are having? Y N

XII. Do you have problems with your ears? Y N
 Dizziness? Y N Ringing? Y N

Please do not write in this space.

- XIII. Have you had any changes in your vision? Y N
 Do you get visual disturbances along with headaches? Y N
 When was the last time you had your eyes checked? _____
- XIV. Do you have trouble sleeping? Y N
 Do you feel rested when you wake up? Y N
 How many hours do you sleep? _____
 How long does it take you to fall asleep? _____
 How many times do you awaken during the night? _____
 Do you consider yourself under a lot of stress? Y N
 Do you worry? Y N
 Do you ever get depressed? Y N
 How often? _____
- Have you ever had a stomach problem? Y N
 Ulcers? Y N
- Rate the nutrition of your diet:
 Excellent Could be better Poor
- Do you use vitamin supplements? Y N
 Do you exercise? Y N
- XV. Do you have or have you had arthritis? Y N
 Have you been treated for any other painful condition
 in the last three years other than your present problem? Y N
 Explain _____

Please do not write in this space.



On the diagram below please indicate any other areas that are painful:

Please do not write in this space.

- XVI. Have you had any prior treatment for TMJ problems? Y N
- Appliance/Splint? Y N When? _____ Did it help? Y N
- Nightguard? Y N When? _____ Did it help? Y N
- Bite adjustment? Y N When? _____ Did it help? Y N
- Orthodontics? Y N When? _____ Did it help? Y N
- Other _____

- XVII. Please list, in chronological order, health care providers
you have seen for this problem:

<u>Date</u>	<u>Doctor or provider</u>	<u>Treatment</u>	<u>Did it help?</u>
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N

- XVIII. Describe the problem (s) in your own words:

- XIX. How have these problems affected your life? Does it keep you from doing
anything that you want to do? (work, play, chores, eating, talking)

XX. Is there anything else that I should know about?

XXI. So that I can better understand your pain, please complete the following:

What does your pain feel like? Some of the words below describe your present pain.

Circle all the words that describe it.

Flickering
Quivering
Pulsing
Throbbing
Beating
Pounding

Jumping
Flashing
Shooting

Pricking
Boring
Drilling
Stabbing
Lancinating

Sharp
Cutting
Lacerating

Pinching
Pressing
Gnawing
Cramping
Crushing

Tugging
Pulling
Wrenching
Searing

Hot
Burning
Scalding
Stinging

Tingling
Itchy
Smarting
Aching

Dull
Sore
Hurting
Splitting
Heavy

Tender
Taut
Rasping

Tiring
Exhausting

Sickening
Suffocating

Fearful
Frightful
Terrifying
Vicious

Punishing
Grueling
Cruel

Wretched
Blinding

Annoying
Troublesome
Miserable
Intense
Unbearable

Spreading
Radiating
Penetrating
Piercing

Tight
Numb
Drawn
Squeezing
Tearing

Cool
Cold
Freezing

Nagging
Nauseating
Agonizing
Dreadful
Torturing

Please provide the names and contact information for doctors (Dentists, Medical Doctors, and Therapist) you are currently seeing and those you have seen in the past.

Currently Seeing	No Longer See	Keep them updated with my progress
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Name Phone # E-Mail
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Name Phone # E-Mail
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Name Phone # E-Mail
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Name Phone # E-Mail
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Name