

Patient Questionnaire

OFFICE USE

Patient ID: _____

NAME: _____

TODAY'S DATE _____

First Middle Initial Last

DATE OF BIRTH: _____ MALE FEMALE

Version:
LVICOMBINEDQ

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

Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

Number

#1 = the most severe symptom

- _____ TMD / PAIN COMPLAINTS
- _____ Difficulty Swallowing
- _____ Dizziness
- _____ Facial Pain
- _____ Headaches
- _____ Jaw Clicking
- _____ Jaw Locking
- _____ Jaw Pain
- _____ Limited Mouth Opening
- _____ Migraines
- _____ Morning Head Pain
- _____ Morning Hoarseness
- _____ Neck Pain
- _____ Nocturnal Teeth Grinding
- _____ Pain when Chewing

Other - Write in:

Number

#1 = the most severe symptom

- _____ Ringing in the Ears
- _____ SLEEP BREATHING COMPLAINTS
- _____ CPAP Intolerance
- _____ Difficulty Falling Asleep
- _____ Fatigue
- _____ Frequent Heavy Snoring
- _____ Frequent Heavy Snoring Which Affects the Sleep of Others
- _____ Gasping when Waking Up
- _____ Nighttime Choking Spells
- _____ Significant Daytime Drowsiness
- _____ Sleepy while Driving
- _____ Witnessed Apneic Events

Periodontal Questions

- __Yes __No Do your gums ever bleed?
- __Yes __No Have your gums receded, or do your teeth look longer?
- __Yes __No Have you ever been told that you have gum problems, gum infection or gum inflammation?
- __Yes __No Have you had any adult teeth extracted due to gum disease?
- __Yes __No Diet limited to liquid foods
- __Yes __No Diet limited to semisolid or soft foods
- __Yes __No Difficulty chewing
- __Yes __No Difficulty speaking
- __Yes __No Difficulty swallowing
- __Yes __No Digestive problems
- __Yes __No Gagging easily
- __Yes __No Mouth sores
- __Yes __No Nutritional disorder
- __Yes __No Numbness of lower lip
- __Yes __No Numbness in jawbone
- __Yes __No Tingling in jawbone
- __Yes __No Pain in jawbone
- __Yes __No Pain when chewing
- __Yes __No Pain when swallowing
- __Yes __No Poorly fitting upper dental appliance
- __Yes __No Swollen gums
- __Yes __No Sore or sensitive gums
- _____ How often do you floss?
(Choose ONE from below)
- _____ weekly
- _____ 2 or 3 times a week
- _____ not at all
- _____ daily

Other _____

Patient Signature _____

Date _____

Page 1

Symptoms

- HEAD PAIN
__Yes __No Entire head (Generalized)
[L] [R] [B] Front of your head (Frontal)
__Yes __No Top of the Head
[L] [R] [B] Back of your head
[L] [R] [B] In your temples
- JAW PAIN
[L] [R] [B] Jaw pain - on opening
[L] [R] [B] Jaw pain - while chewing
[L] [R] [B] Jaw pain - at rest
- JAW SYMPTOMS
[L] [R] [B] Jaw clicking
__Yes __No Jaw locks closed
__Yes __No Jaw locks open
__Yes __No Jaw popping
__Yes __No Teeth grinding
- MOUTH AND NOSE RELATED
CONDITION
__Yes __No Broken teeth
__Yes __No Teeth clenching
__Yes __No Dry mouth
__Yes __No Frequent snoring
__Yes __No Frequent biting of cheek
__Yes __No Burning tongue
- EAR RELATED CONDITIONS
__Yes __No Buzzing in the ears
__Yes __No Tinnitus (ringing in the ears)
__Yes __No Ear pain
__Yes __No Ear congestion
__Yes __No Pain in front of the ear
__Yes __No Hearing loss
__Yes __No Recurrent ear infections

__Yes __No Pain behind the ear

EYE RELATED CONDITIONS

- Double Vision, Photophobia in PAIN
Hx
__Yes __No Blurred vision
__Yes __No Eye pain
__Yes __No Pain or pressure behind the eyes

THROAT, NECK & BACK RELATED CONDITIONS CONTINUED

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

Other _____

HEAD PAIN HISTORY

Pain Qualities

--- LOCATION ---

_____ Which side are the headaches worse?
(Choose ONE from below)

_____ both sides

_____ the left side

_____ the right side

_____ Headache spreads to
(Choose ONE from below)

_____ the temple

_____ the back of the head

_____ the forehead

--- SEVERITY ON A SCALE OF 0-10 ---

--- 0=No Pain 10=Worst Pain Imaginable ---

_____ Jaw Pain on a Numeric Pain Scale

_____ Headaches on a 0-10 Pain Scale

_____ Neck Pain on a Numeric Pain Scale

_____ Facial Pain on a 0-10 Pain Scale

--- FREQUENCY ---

__Yes __No Occasional

__Yes __No Frequent

__Yes __No Constant

--- DURATION ---

__Yes __No Seconds

__Yes __No Minutes

__Yes __No Hours

__Yes __No Days

__Yes __No Weeks

When having pain do you experience:

__Yes __No Dizziness

__Yes __No Double vision

__Yes __No Fatigue

__Yes __No Nausea

__Yes __No Sensitivity to light (photophobia)

__Yes __No Sensitivity to noise

__Yes __No Throbbing

__Yes __No Vomiting

__Yes __No Burning

HISTORY OF SYMPTOMS

When did your condition first occur? _____

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

- Pick one:*
- | | | | |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Motor vehicle accident | <input type="checkbox"/> Motorcycle accident | <input type="checkbox"/> Work related incident | <input type="checkbox"/> Accident |
| <input type="checkbox"/> Athletic endeavor | <input type="checkbox"/> Fight | <input type="checkbox"/> Playground incident | |
| <input type="checkbox"/> Illness | <input type="checkbox"/> Injury | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Fall | _____ | |

If accident, enter date: _____

Is there anything that makes your pain or discomfort worse? _____

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




What other information is important to your pain or condition? _____

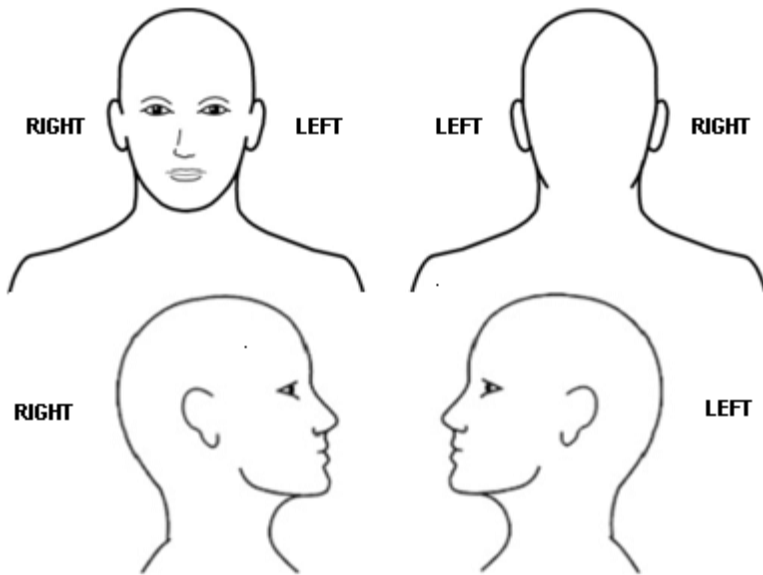
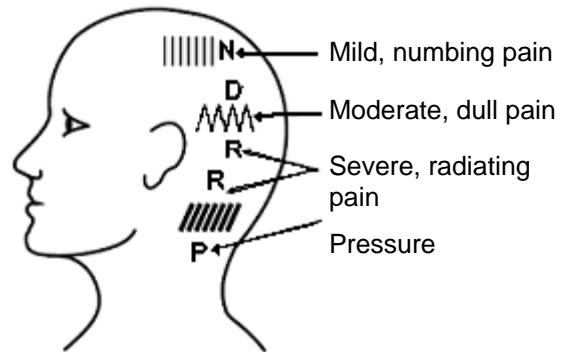
LIST ANY TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:




Practioner	Specialty	Treatment & Approximate date
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

- | | | |
|---------------|---|--------------------|
| MILD PAIN |  | B Burning |
| | | D Dull |
| | | H Numbing |
| MODERATE PAIN |  | P Pressure |
| | | S Sharp |
| SEVERE PAIN |  | T Tingling |
| | | R Radiating |



- | | | | | |
|---------------|---|------------------|--------------------|-------------------|
| Legend |  MILD PAIN | B Burning | P Pressure | T Tingling |
| |  MODERATE PAIN | D Dull | R Radiating | |
| |  SEVERE PAIN | N Numbing | S Sharp | |

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

✓ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (i.e. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopping for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score: _____ (Add columns 0-3)

SLEEP STUDIES

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

Sleep Center Name _____
and Location _____

Sleep Study Date _____

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The evaluation confirmed a diagnosis of mild moderate severe obstructive sleep apnea

The evaluation showed

	during REM	Supine	Side
an RDI of _____	_____	_____	_____
an AHI of _____	_____	_____	_____

a nadir SpO2 of _____ T90 _____

Slow Wave Sleep Decreased None

REM Sleep Decreased None

Patient Signature _____

Date _____

SLEEP HISTORY

Previous Diagnosis

Yes No Have you been previously diagnosed with Obstructive Sleep Apnea?

If Yes, how long ago was it? _____ Years ago Months ago Days ago
number

Snoring is reported as:

_____ Frequency
 _____ (Choose ONE from below)
 _____ seldom
 _____ never
 _____ daily
 _____ often

_____ Severity
 _____ (Choose ONE from below)
 _____ light
 _____ moderate
 _____ loud

Yes No Worse during supine sleep
 Yes No Worse following alcohol late at night

Sleep:

Yes No Bruxism
 Yes No Dry mouth
 Yes No Excessive movements
 Yes No Gasping
 _____ Getting up <number of times> per night
 Yes No Nightmares
 Yes No Reading or watching TV before sleeping
 Yes No Restless legs
 Yes No Waking up and having difficulty returning to sleep
 Yes No Dreaming
 _____ Frequency of nocturnal urination (# of times)

Witnessed apneas are:

Yes No Worse during supine sleep
 Yes No Worse following alcohol late at night

Wake

Yes No Awakens unrefreshed
 Yes No Has morning headaches
 Yes No Has problematic daytime sleepiness
 _____ Naps
 _____ (Choose ONE from below)
 _____ naps daily
 _____ never napping
 _____ occasionally naps

FATIGUE SCALE

During the past week:

	No <<			>> Yes			
	1	2	3	4	5	6	7
I felt fatigued and had less motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued and did not desire to exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigue that interfered with my physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued which caused me frequent problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued which prevented sustained physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fatigued and couldn't carry out certain duties and responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue was among my three most disabling symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue interfered with my work, family or social life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score: _____

Patient Signature _____

Date _____

CPAP Intolerance (Continuous Positive Airway Pressure device)

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

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mask leaks | <input type="checkbox"/> Yes <input type="checkbox"/> No Claustrophobic associations |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Inability to get the mask to fit properly | <input type="checkbox"/> Yes <input type="checkbox"/> No An unconscious need to remove the CPAP |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Discomfort from headgear | <input type="checkbox"/> Yes <input type="checkbox"/> No Inability to sleep well |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Disturbed or interrupted sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No CPAP does not resolve symptoms |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Noise disturbing sleep and/or bed partner's sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No Noisy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No CPAP restricted movements during sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No Cumbersome |
| <input type="checkbox"/> Yes <input type="checkbox"/> No CPAP does not seem to be effective | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pressure on the upper lip causing tooth related problems | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Latex allergy | |

Other _____

OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders?

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Dieting | <input type="checkbox"/> Yes <input type="checkbox"/> No Smoking cessation |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss | <input type="checkbox"/> Yes <input type="checkbox"/> No CPAP |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Surgery (Uvuloplasty) | <input type="checkbox"/> Yes <input type="checkbox"/> No BiPap |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Surgery (Uvulectomy) | <input type="checkbox"/> Yes <input type="checkbox"/> No Uvuloplasty (but continues to have symptoms) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pillar procedure | <input type="checkbox"/> Yes <input type="checkbox"/> No Uvulectomy (but continues to have symptoms) |

Other _____

Orthodontic Concerns

- | | |
|---|--|
| REASONS FOR VISIT | <input type="checkbox"/> Yes <input type="checkbox"/> No Prominent jaw |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Accident | <input type="checkbox"/> Yes <input type="checkbox"/> No Receded jaw |
| <input type="checkbox"/> Yes <input type="checkbox"/> No "Buck" or protruding teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No Tooth spacing - excessive |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Crowded teeth | TENDENCIES |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Irregularly shaped teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No Clenching |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mismatched bite | <input type="checkbox"/> Yes <input type="checkbox"/> No Grinding |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Missing tooth | <input type="checkbox"/> Yes <input type="checkbox"/> No Finger sucking |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Orthodontic second opinion | <input type="checkbox"/> Yes <input type="checkbox"/> No Mouth Breathing |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Overbite | <input type="checkbox"/> Yes <input type="checkbox"/> No Nail Biting |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Overly small mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No Tongue habit |

Other _____

PAST PATIENT EXPERIENCE

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No My first item | > What are your personal concerns? |
| > What are your personal interests for treatment? | _____ On as scale of 1-10 how do you feel about keeping your teeth |
| > Is there anything you would change about the appearance of your teeth? | > What is your timeline for treatment? |

Other _____