

# PATIENT QUESTIONNAIRE

## T.M.J., SLEEP APNEA AND SNORING

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Age: \_\_\_\_\_ Sex: Male Female Height \_\_\_\_\_ Weight \_\_\_\_\_

Please state your chief complaint(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

One or more of the following may be indicative of **Temporomandibular Joint Disorders or Musculoskeletal Dysfunction** of the head and neck. Please circle any of the following symptoms if they apply. Please write any other pertinent information not covered previously. Use extra sheets of paper if necessary.

**PAIN IN ANY OF THE FOLLOWING (L=left; R=right)**

Ears	L	R	Upper Jaw	L	R	Neck	L	R	Temples	L	R
Jaw Joint	L	R	Lower Jaw	L	R	Shoulder	L	R	Cheek Area	L	R
Around Eyes	L	R	Tongue	L	R	Forehead	L	R			

**HAVE YOU EVER EXPERIENCED OR DO YOU CURRENTLY SUFFER FROM:**

Headaches	YES	NO	Teeth sensitive to hot/cold/ biting/chewing	YES	NO
Nausea-upset stomach	YES	NO	Clenching/grinding teeth	YES	NO
Dizziness (vertigo)	YES	NO	Bite lips/cheeks regularly	YES	NO
Ringing/Buzzing in ears	YES	NO	Constant tiredness	YES	NO
Fullness/blockage in ears	YES	NO	Sinus problems	YES	NO
Loud Snoring	YES	NO	Subjective hearing loss	YES	NO
Inability to open/close mouth	YES	NO	Grating sound in joints		
Daytime sleepiness	YES	NO	__right or __left?	YES	NO
Morning dry mouth	YES	NO	Clicking/popping in joints		
Mouth breathing	YES	NO	__right or __left?	YES	NO
Difficulty breathing/chocking- during sleep	YES	NO	Arthritis	YES	NO
Teeth separation/crowding	YES	NO	Nervousness/insomnia	YES	NO
Loose teeth	YES	NO	Other symptoms: _____		

**HAVE YOU EVER HAD:**

Cervical traction/neck brace	YES	NO	General anesthesia	YES	NO
Teeth Straightened (orthodontia)	YES	NO	Allergies as a child/adult	YES	NO
Teeth removed for orthodontia	YES	NO	Injury to jaw or face	YES	NO
Wisdom teeth removed	YES	NO			

Do you chew gum?      Frequently      Moderately      Infrequently      Never  
 Do symptoms effect one or both jaws?      Right      Left      Both      If both, which is most effected Left or Right  
 How long have you been bothered by this problem?      \_\_years      \_\_months      \_\_weeks      \_\_days  
 Do you attribute the symptoms to an accident?      Yes      No      If yes, please explain: \_\_\_\_\_

Have you ever been told that you grind your teeth (brux) at night during sleep?      YES      NO  
 Is there anyone in your family with a similar problem?      YES      NO

Are you now on pain medication?    YES    NO    If yes, what kind and how much: \_\_\_\_\_

Describe any other treatment for this problem (medicine, exercise, dental appliance.) \_\_\_\_\_

Please list chronologically names and types of doctors and their locations, whom you have seen in the past for this or related problems. Please use additional paper if necessary.

PHYSICIAN'S NAME	ADDRESS	SPECIALTY	REASON

Please write any other pertinent information that has not been covered previously. Use additional sheets if necessary.

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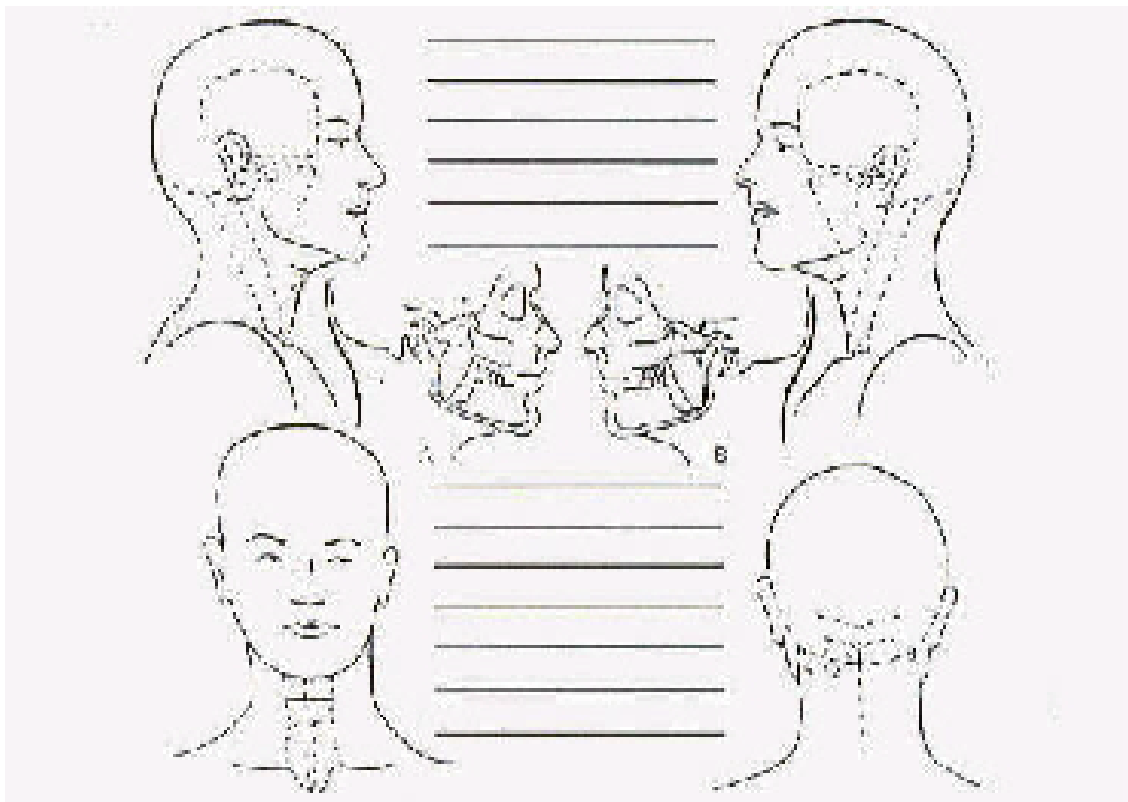
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Please place a red "X" on the diagram to indicate areas of pain or tenderness. (The horizontal lines are provided for additional explanations.)



## SLEEP APNEA AND SNORING

Please answer the following questions by indicating frequency according to these guidelines:

**Daily:** Every or almost every night or day  
**Often:** At least once or twice per week  
**Infrequently:** Less than once a week  
**Never**

During your usual sleep, have you noticed or have you been told that you do the following:

	Daily	Often	Infrequently	Never
Snore loudly	_____	_____	_____	_____
Choke, struggle for breath, stop breathing	_____	_____	_____	_____
Awaken repeatedly because of breathing problem	_____	_____	_____	_____
Toss and turn frequently	_____	_____	_____	_____
Kick or jerk legs repeatedly	_____	_____	_____	_____

When you wake-up after your usual sleep, how often do you experience the following:

	Daily	Often	Infrequently	Never
Headache	_____	_____	_____	_____
Dry Mouth	_____	_____	_____	_____
Feel tired or unrested	_____	_____	_____	_____

During the time when you are usually awake (daytime and evening), how often do you become irresistibly sleepy or do you fall asleep in the following situation:

	Daily	Often	Infrequently	Never
After a meal	_____	_____	_____	_____
Reading or watching T.V.	_____	_____	_____	_____
At church or school	_____	_____	_____	_____
At work	_____	_____	_____	_____
While a passenger in a vehicle	_____	_____	_____	_____
While driving a vehicle	_____	_____	_____	_____

Do you have trouble breathing through your nose:

	Daily	Often	Infrequently	Never
Daytime	_____	_____	_____	_____
Nighttime, in bed	_____	_____	_____	_____

Do you consume an alcoholic beverage or take sedatives:

	Daily	Often	Infrequently	Never
Daytime	_____	_____	_____	_____
Nighttime, in bed	_____	_____	_____	_____

Have you had or used any of the following:

Nose broken	Y	N	Nose surgery	Y	N	Tonsillectomy	Y	N
Hay Fever	Y	N	Sinus problems	Y	N	Antihistamines	Y	N
Cigarettes	Y	N	Nasal Sprays	Y	N	Prev. Treatment	Y	N

Do you take medications for:

Heart problems	Y	N	Respiratory condition	Y	N
Thyroid problems	Y	N	Metabolism (weight)	Y	N

1. How long have you been aware of your snoring? \_\_\_\_\_
2. Has it caused problems for relatives/friends? \_\_\_\_\_
3. Have you been told your breathing stops while asleep? \_\_\_\_\_
4. Have you been told you move around a lot while asleep? \_\_\_\_\_
5. What position do you sleep in? \_\_\_\_\_ side \_\_\_\_\_ back \_\_\_\_\_ stomach
6. About how many times per night do you wake up? \_\_\_\_\_
7. Do you have any difficulty falling asleep at night? \_\_\_\_\_
8. How many hours of sleep per night do you get? \_\_\_\_\_
9. Do you often wake up with a headache? \_\_\_\_\_
10. Does a small amount of alcohol give you a headache? \_\_\_\_\_
11. Do you feel sleepy during the day? \_\_\_\_\_ frequently \_\_\_\_\_ occasionally \_\_\_\_\_ seldom or never
12. What other doctors have you seen about snoring or apnea? \_\_\_\_\_  
\_\_\_\_\_
13. Have you had a sleep lab study? \_\_\_\_\_
14. Do you have difficulty breathing through your nose? \_\_\_\_\_
15. Have you gained weight recently? \_\_\_\_\_ How much? \_\_\_\_\_
16. Present weight? \_\_\_\_\_ Height? \_\_\_\_\_ ft. \_\_\_\_\_ in.
17. Do you know if you have any heart irregularities? \_\_\_\_\_
18. Do you have high blood pressure? \_\_\_\_\_ What is yours? \_\_\_\_\_
19. Do you have any loss of memory? \_\_\_\_\_ Depression? \_\_\_\_\_
20. Do your jaw joints click? \_\_\_\_\_ Stick? \_\_\_\_\_ Hurt? \_\_\_\_\_

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**PATIENT'S SIGNATURE**

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**DATE**