LAWRENCE E. WRIGHT, D.D.S., M.S.

Diplomate

Board of Orthodontists

[redacted]

767 National Road, Wheeling, WV 26003

TMJ / PAIN HEADACHE QUESTIONNAIRE

Please answer all questions so that we may be able to manage your problem.

Name _____ Age _____ Sex _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Phone: (AC) _____ Work _____ Home _____

Occupation _____

How did you learn about Dr. Wright's Office? _____

1. My last medical examination was on _____

   Physician's Name / Address / Phone _____

2. My last dental examination was on _____

   Dentist's Name / Address / Phone _____

3. List in chronological order the Dentists and Physicians who have treated you for your pain problem (Names / Addresses)

4. Have you ever been hospitalized for any serious illness or operation? ☐ Yes ☐ No

   If yes, please explain with dates _____

5. Do you regularly take any medication or pills? ☐ Yes ☐ No

   If yes, please explain with dates and dosages if possible _____

6. Do you have any allergies? (environmental or drugs?) ☐ Yes ☐ No

   If yes, please explain _____

   _____

   (Iodine? - IVP dye?) _____

7. Have you ever had a bad reaction to medication other than allergic in nature? ☐ Yes ☐ No

   _____

8. Have you ever been treated for any mental or emotional problems? ☐ Yes ☐ No

   If yes, please explain with dates _____

   _____

9. Have you experienced numbness of one side of the face or body? ☐ Yes ☐ No
10. Do you suffer from chronic headache? _____ Ear pain? _____ Ear infections? _____

    _____

11. Do you suffer from stomach trouble or ulcer? ☐ Yes ☐ No
12. Are you suffering from rheumatism or arthritis? What kind: Rheumatoid _____

    Degenerative _____ Traumatic _____ Gout _____
13. Do your muscles and joints ever feel stiff or swollen? ☐ Yes ☐ No
14. Do you ever experience muscle aches or spasms? If so, where? _____

    _____
15. Do you have trouble sleeping? ☐ Yes ☐ No Use sleeping pills? ☐ Yes ☐ No
16. Do you suffer from low back pain? ☐ Yes ☐ No
17. Do you have any eye problems? ☐ Yes ☐ No glasses? ☐ Yes ☐ No surgery? ☐ Yes ☐ No

    blurred vision? ☐ Yes ☐ No double vision? ☐ Yes ☐ No "spots"? ☐ Yes ☐ No

    pain behind the eye(s)? ☐ Yes ☐ No
18. Do you have sinus problems? ☐ Yes ☐ No
19. Do your salivary glands ever hurt or swell? ☐ Yes ☐ No
20. Have you ever had dental pain or infection? ☐ Yes ☐ No
21. Have you had your wisdom teeth removed? ☐ Yes ☐ No
22. Difficulty swallowing? ☐ Yes ☐ No Painful? ☐ Yes ☐ No
23. When did your problem with pain (TMJ, FACE, HEAD, NECK) begin? (Please use dates if possible). _____

    _____

    _____

    _____

    _____
24. How long has this problem persisted? _____

    Has there been periods of remission? ☐ Yes ☐ No
25. What part of the day is the pain or functional problem most severe? _____

SYMPTOMS

Circle all the symptoms that apply to you: (right, left, both)

Ear pain	R	L	B	Hearing problems	R	L	B
Face pain	R	L	B	Headaches	R	L	B
Neck pain	R	L	B	Frequency of headaches	_____		
Eye pain or burning	R	L	B	Sore / sensitive teeth			
Uncomfortable dental bite	R	L	B	Dizziness / loss of balance			
Jaw pain	R	L	B	Ringing in the ears	R	L	B

IS THIS PAIN?

Constant	Worse in the morning
Aching	Worse in the afternoon
Stabbing	Awakens you at night
Burning	When chewing
Shooting	Electrical

DOES YOUR JAW?

Click or pop	R	L	B	Lock open	R	L	B
Catch or "hangup"	R	L	B	Lock closed	R	L	B
Make a grinding noise	R	L	B	Deviate on one side	R	L	

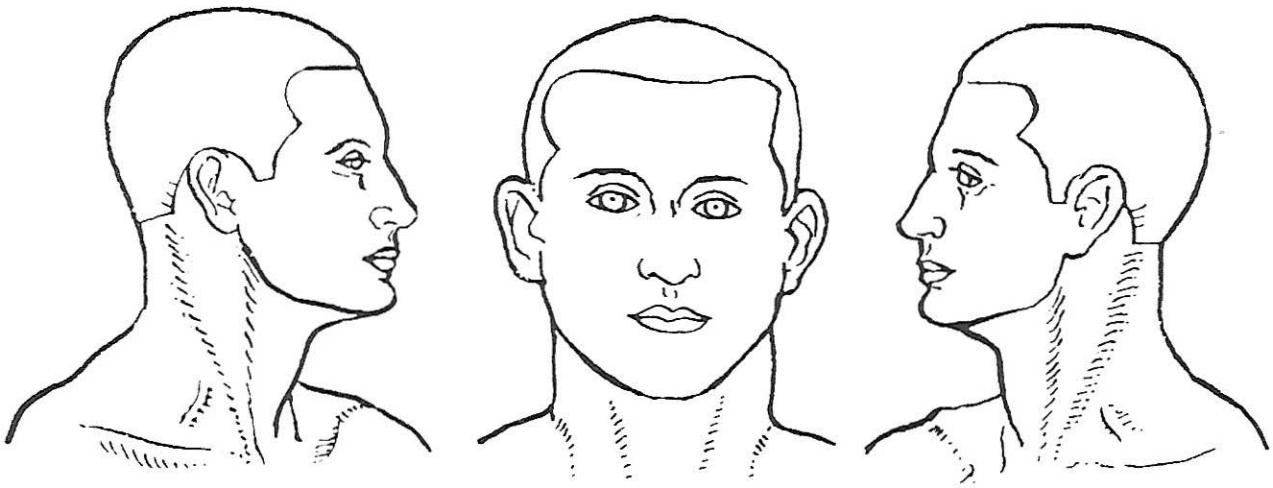
27. If none of these symptoms is occurring now, have any of these symptoms occurred in the past? ☐ Yes ☐ No

Please explain _____

_____

_____

28. Draw an outline and shade the area of your pain:



29. Have you ever been involved in an accident or had a sports injury? ☐ Yes ☐ No

If yes, explain _____

_____

_____

Any injury to the head and neck? ☐ Yes ☐ No Whiplash? ☐ Yes ☐ No

30. Do you have any oral habits such as grinding or clenching your teeth? ☐ Yes ☐ No

Cheek or lip biting? ☐ Yes ☐ No biting on hard object (ice)? _____

31. Have you ever had orthodontics? ☐ Yes ☐ No (braces) when _____ (age)
How long? _____ Retainer? _____

32. Have you ever had jaw surgery for deformity? ☐ Yes ☐ No
Fracture? ☐ Yes ☐ No Please explain _____

33. Have you had any treatment for your problem? (Underline those that apply)

Bite splint	Dental bite adjustment
Medication	Orthodontics
Physical therapy	Surgery
Counseling	Other _____

34. Are you frequently confined to bed by illness? ☐ Yes ☐ No
35. Are you always in poor health? ☐ Yes ☐ No
36. Do you come from a sickly family? ☐ Yes ☐ No
37. Has pain made work impossible for you? ☐ Yes ☐ No
38. Are you constantly made miserable by poor health? ☐ Yes ☐ No
39. Do you have to lie down and rest often because of pain? ☐ Yes ☐ No
40. Does pain bother you so much you have to keep moving? ☐ Yes ☐ No
41. Has pain interfered with your sex life? ☐ Yes ☐ No
42. Are you unable to do all the things you want because of pain? ☐ Yes ☐ No
43. Do you find that all you can think about is your pain? ☐ Yes ☐ No
44. Do doctors seem to have failed you? ☐ Yes ☐ No
45. Do you keep looking for a specialist to solve your case? ☐ Yes ☐ No
46. Do you have trouble getting doctors to take you seriously? ☐ Yes ☐ No
47. Have some doctors said your pain was imaginary? ☐ Yes ☐ No
48. Do you secretly think your case may be hopeless? ☐ Yes ☐ No
49. Describe your problem in your own words: _____

50. On a scale of 1 thru 10, where would your pain fall in severity? _____