Valley Sleep and TMJ
Sceville Dental Group
Professional care • Personalized solutions

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❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr. ❍ Other

First Name_____ Middle Initial_____ Last Name_____

Responsible Party: (If someone other than patient) Name_____

Who is primary on insurance: ❍ Self ❍ Spouse ❍ Father ❍ Mother Name_____

Date of Birth_____

Patient Information

Street Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Sex: ❍ Male ❍ Female Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

Date of Birth_____ Age_____ Social Security Number_____

Spouse Name_____ Date of Birth_____

Email_____@_____

❍ Employed Student Status: ❍ Full time ❍ Part time

Family Dentist_____ Dentist's Phone_____

Family Physician_____ Dentist's Phone_____

Referred by_____ Physician's Phone_____

MEDICAL HISTORY QUESTIONNAIRE

ALLERGENS

❑ No known allergens	❑ Iodine	❑ Plastic	❑ Antibiotics
❑ Latex	❑ Sedatives	❑ Aspirin	❑ Local Anesthetics
❑ Sleeping pills	❑ Barbituates	❑ Metals	❑ Sulfa drugs
❑ Codeine	❑ Penicillin		

Other_____

CURRENT MEDICATIONS

Medicine	Dosage/Frequency	Reason

OFFICE USE ONLY

I verify that I obtained a copy of the patient's photo ID and insurance card and made a copy of each for our records. Initial_____ Date_____

MEDICAL HISTORY (CONT'D)

Medical Condition	Never	Current	Past	Date/Note
Acid reflux	☐	☐	☐	
Anxiety	☐	☐	☐	
Anemia	☐	☐	☐	
Arthritis	☐	☐	☐	
Atherosclerosis	☐	☐	☐	
Asthma	☐	☐	☐	
Autoimmune disorder	☐	☐	☐	
Bleeding easily	☐	☐	☐	
Blood pressure – High	☐	☐	☐	
Blood pressure – Low	☐	☐	☐	
Bruising easily	☐	☐	☐	
Cancer	☐	☐	☐	
Chemotherapy	☐	☐	☐	
Chronic fatigue	☐	☐	☐	
Chronic pain	☐	☐	☐	
COPD	☐	☐	☐	
Coronary heart disease	☐	☐	☐	
Current pregnancy	☐	☐	☐	
Depression	☐	☐	☐	
Diabetes	☐	☐	☐	
Difficulty Sleeping	☐	☐	☐	
Dizziness	☐	☐	☐	
Emphysema	☐	☐	☐	
Epilepsy	☐	☐	☐	
Fibromyalgia	☐	☐	☐	
Glaucoma	☐	☐	☐	
Gout	☐	☐	☐	
Heart attack	☐	☐	☐	
Heart murmur	☐	☐	☐	
Heart pacemaker	☐	☐	☐	
Heart valve replacement	☐	☐	☐	
Hemophilia	☐	☐	☐	
_____		☐	☐	
_____		☐	☐	
_____		☐	☐	
_____		☐	☐	

Medical Condition	Never	Current	Past	Date/ Note
Hepatitis	☐	☐	☐	
Hypoglycemia	☐	☐	☐	
Immune system disorder	☐	☐	☐	
Insomnia	☐	☐	☐	
Ischemic heart disease (reduced blood supply)	☐	☐	☐	
Kidney Problems	☐	☐	☐	
Liver disease	☐	☐	☐	
Meniere's disease	☐	☐	☐	
Mitral valve prolapsed	☐	☐	☐	
Mood disorder	☐	☐	☐	
Multiple sclerosis	☐	☐	☐	
Muscular dystrophy	☐	☐	☐	
Nasal allergies	☐	☐	☐	
Neuralgia	☐	☐	☐	
Osteoarthritis	☐	☐	☐	
Osteoporosis	☐	☐	☐	
Parkinson's disease	☐	☐	☐	
Prior orthodontic treatment	☐	☐	☐	
Psychiatric care	☐	☐	☐	
Radiation treatment	☐	☐	☐	
Rheumatic fever	☐	☐	☐	
Rheumatoid arthritis	☐	☐	☐	
Sinus problems	☐	☐	☐	
Sleep apnea	☐	☐	☐	
Stroke	☐	☐	☐	
Tendency for ear infections	☐	☐	☐	
Thyroid disorder	☐	☐	☐	
Tuberculosis	☐	☐	☐	
Tumors	☐	☐	☐	
Urinary disorder	☐	☐	☐	
Wisdom teeth extraction	☐	☐	☐	
_____		☐	☐	
_____		☐	☐	
_____		☐	☐	
_____		☐	☐	

SURGICAL OPERATIONS

☐ Adenoids ☐ Heart ☐ Neck ☐ Appendectomy ☐ Hernia repair
☐ Periodontal ☐ Back ☐ Jaw joint ☐ Thyroid ☐ Ear
☐ Lung ☐ Tonsillectomy ☐ Gallbladder ☐ Nasal ☐ Uvulectomy (UPPP)

Other _____

FAMILY HISTORY

Has any member of your family (parent, sibling, or grandparent) had:

☐ Cancer ☐ Stroke ☐ Father snores ☐ Heart disease ☐ Sleep disorder
☐ Mother snores ☐ Diabetes ☐ Obesity ☐ Father has sleep apnea ☐ High blood pressure
☐ Thyroid disorder ☐ Mother has sleep apnea

Other _____

SOCIAL HISTORY

Patient's Occupation _____ Employer _____

Tobacco Use: Cigarettes: ○ Never Smoked ○ Current Smoker ○ Quit
# of pack per day _____ When did you quit?
# of years _____ _____

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use: Do you drink alcohol? ○ Yes ○ No If yes, # of drinks per week: _____

Caffeine Intake: ○ None ○ Coffee/Tea/Soda # of cups per day _____

Regular exercise: ○ Yes ○ No

HEAD, NECK AND FACIAL PAIN QUESTIONNAIRE

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, # 2 the next most severe, etc.

____ Jaw pain ____ Ringing in the ears ____ Jaw clicking ____ Dizziness
____ Jaw locking ____ Nocturnal teeth grinding ____ Limited mouth opening ____ Frequent Heavy Snoring
____ Facial pain ____ Pain when chewing ____ Neck pain ____ Fatigue
____ Headaches ____ Throat pain ____ Migraines ____ Tooth Pain
____ Morning head pain ____ Ear pain Other _____

SYMPTOMS

L - Left, R - Right, B - Both

HEAD PAIN

L R B Entire head (Generalized)										
Severity			Frequency			Duration				
Mild	Mod.	Severe	Occas.	Freq	Constant	Sec	Min	Hrs	Days	Wks
○	○	○	○	○	○	○	○	○	○	○

L R B Top of the head (Parietal)										
Severity			Frequency			Duration				
Mild	Mod.	Severe	Occas.	Freq	Constant	Sec	Min	Hrs	Days	Wks
○	○	○	○	○	○	○	○	○	○	○

L R B Front of your head (Frontal)										
Severity			Frequency			Duration				
Mild	Mod.	Severe	Occas.	Freq	Constant	Sec	Min	Hrs	Days	Wks
○	○	○	○	○	○	○	○	○	○	○

L R B Back of your head (Occipital)										
Severity			Frequency			Duration				
Mild	Mod.	Severe	Occas.	Freq	Constant	Sec	Min	Hrs	Days	Wks
○	○	○	○	○	○	○	○	○	○	○

L R B In your temples (Temporal)										
Severity			Frequency			Duration				
Mild	Mod.	Severe	Occas.	Freq	Constant	Sec	Min	Hrs	Days	Wks
○	○	○	○	○	○	○	○	○	○	○

SYMPTOMS

Please mark with "x" all those that apply to you.

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
- [ ] L [ ] R [ ] B Jaw popping
- [ ] Jaw locks closed
- [ ] Jaw locks Open
- [ ] Teeth grinding
- [ ] Teeth clenching

MOUTH AND NOSE RELATED CONDITION

- [ ] Burning tongue
- [ ] Frequent biting of cheek
- [ ] Frequent snoring
- [ ] Past history of broken teeth
- [ ] Dry mouth

EAR RELATED CONDITIONS

- [ ] L [ ] R [ ] B Buzzing in the ears
- [ ] L [ ] R [ ] B Tinnitus (ringing in the ears)
- [ ] L [ ] R [ ] B Ear pain
- [ ] L [ ] R [ ] B Ear Congestion
- [ ] L [ ] R [ ] B Pain in front of the ear
- [ ] L [ ] R [ ] B Hearing loss
- [ ] L [ ] R [ ] B Pain behind the ear
- [ ] Recurrent ear infections

EYE RELATED CONDITIONS

- [ ] L [ ] R [ ] B Blurred vision
- [ ] Eye pain
- [ ] Pain or pressure behind the eyes

THROAT, NECK & BACK RELATED CONDITION

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

Other _____

_____

_____

_____

HISTORY OF SYMPTOMS

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

- ☐ a motor vehicle accident
- ☐ a motorcycle accident
- ☐ a work related incident
- ☐ a playground incident
- ☐ an athletic endeavor
- ☐ a fight
- ☐ a fall
- ☐ an accident
- ☐ an illness
- ☐ an injury
- ☐ orthodontics
- ☐ dental procedures
- ☐ whiplash
- ☐ _____

When did the pain or condition first occur? _____

_____

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 regarding the pain or condition? _____

_____

_____

_____

_____

HISTORY OF TREATMENT

Practitioner's Name	Specialty	Treatment	Approximate Date

HEAD PAIN HISTORY

Which side are the headaches worse?

☐ both sides ☐ the left side ☐ the right side

Headache spreads to

☐ the temple ☐ the back of the head ☐ the forehead ☐ top of the head

Other _____

SEVERITY ON A SCALE OF 0-10

0=No Pain; 10=Worst Pain Imaginable

_____ Jaw Pain on a 0-10 Pain Scale

_____ Neck Pain on a 0-10 Pain Scale

_____ Headaches on a 0-10 Pain Scale

_____ Facial Pain on a 0-10 Pain Scale

FREQUENCY

☐ occasional (0-3/mo) ☐ frequent (3-6/mo) ☐ constant

Other _____

DURATION

☐ Seconds ☐ Minutes ☐ Hours ☐ Days ☐ Weeks

When having pain do you experience:

☐ Dizziness
☐ Double vision
☐ Fatigue
☐ Nausea
☐ Sensitivity to light (photophobia)
☐ Sensitivity to noise
☐ Throbbing
☐ Vomiting
☐ Burning

Other _____

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature: _____ Date: ____/____/____

I certify that the medical history information is complete and accurate

Patient Signature: _____ Date: ____/____/____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY

Using this key below and as shown in example, please draw your pain patterns, in the diagram below.

MILD PAIN ||||||

MODERATE PAIN ^^^

SEVERE PAIN //////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating