BERGER DENTAL GROUP, P.A.

Diagnosis and Treatment of
Temporomandibular Disorders and Head, Neck, and Facial Pain

PATIENT INFORMATION

INSTRUCTIONS: Please answer all questions as accurately and thoroughly as possible. The completeness of your answers directly affects the diagnostic decisions made on your behalf. Although some questions may not seem applicable to you, there is a specific reason behind each question asked. This information will remain confidential at all times.

We realize that it will take considerable time to complete this form. We can assure you this information will be reviewed in detail before, during, and after your examination.

NAME ____ DATE ___________ SSN ________________

HISTORY

Describe the problem you have with your jaws or teeth in your own words.

____
____
____
____
____
____
____
____

When did you first begin to notice the problems for which you are seeking help? ___________ (Date)

What started or set off the problem? ____
____
____
____

What time of day is the problem at its worst? Morning Midday Evening Night
What time of day is the problem at its best? Morning Midday Evening Night
What do you do to control the pain or dysfunction? ____
____

Does any member of your family have the same or similar problem? Yes No
If yes, please explain. ____

Have you had any falls, blows or other injuries to your chin or jaw? Yes No
How? ____ When? _________________________

Have you had any falls, blows or other injuries to your head? Yes No
How? ____ When? ________________________

Have you had any falls, blows, or other injuries to your neck? Yes No
How? ____ When? ________________________

Do you have any scars on or around your chin? Yes No

Realizing that you are visiting this office for diagnosis and treatment of your problem, do you have an option about what should be done to correct your present condition?

____
____
____

PREVIOUS TREATMENT

Please list all Dentists, Physicians, Chiropractors, Physical Therapists, Pain Centers or other therapists who have been involved in diagnosing or treating you for this condition. Please list in chronological order if possible. Include the individual's name, specialty, address and phone number if possible. Please list any success or failures that you experienced with each. If additional space is needed, continue on additional paper.

____
____
____
____
____
____
____

Have you had an MRI or CAT scan of your head? Yes No
Date __________ Location ________________ Who ordered it? ______________________________

SURGICAL HISTORY

Please list all surgeries you have had and approximate dates:

____
____
____
____
____

MEDICAL HISTORY
Height ____________ Weight ____________

Please encircle YES or NO - If YES, please fill in details.

YES NO Have you had rheumatic fever? When? ____

YES NO Do you have high or low blood pressure? Is it controlled? ________________________

YES NO Have you had pains in the chest or shortness of breath? __________________________

YES NO Has your physician ever told you that you are anemic? __________________________

YES NO Have you ever had a stroke? When? ____

YES NO Have you ever had diabetes? How is it controlled? ______________________________

YES NO Are you allergic to any medication? What? ____________________________________

YES NO Have you been advised not to take any medication? What? ______________________

YES NO Have you ever had tuberculosis? When? _______________________________________

YES NO Have you ever had hepatitis? When? ____

YES NO Have you been exposed to or contracted: Herpes? ______________________________

YES NO Have you been exposed to or contracted: AIDS? _______________________________

YES NO Do you have a current medical problem? What? _______________________________

YES NO Do you have any heart trouble? What kind? ___________________________________

YES NO Do your ankles ever swell? ____

YES NO Are you subject to fainting or dizziness? When? ______________________________

YES NO Do you have headaches? How often? ____

YES NO Do you have problems with insomnia? How often? _____________________________

YES NO Do you have a nervous disorder? How is it controlled? _________________________

YES NO Do you take tranquilizers or sedatives? How often? ____________________________

YES NO Do you take aspirin? How often? ____

YES NO Do you have asthma or hay fever? How is it controlled? ________________________

YES NO Do you have arthritis? How is it controlled? ___________________________________

YES NO Have you had any major operations? What kind? ____________________________

YES NO Have you ever been involved in a serious accident? Date: _______________________

YES NO Have you lost or gained weight within the last year? How much? ________________

YES NO Do you become fatigued easily? At what time of day? ___________________________

FOR WOMEN:

YES NO Do you have children? How many? ________________ How old? ________________

YES NO Are you pregnant? Expected delivery date: ____________________________________

YES NO Do you have a history of previous miscarriages? ______________________________

YES NO Are you taking birth control pills? For how long? ______________________________

YES NO Do you experience irregular menstrual cycles? _________________________________

YES NO Have you had surgery of the female organs (including tubal ligation)? _____________

YES NO Have you reached menopause? If so, are you taking supportive medication?
____

YES NO Have you been told, or do you suspect, you may have Pre-Menstrual Syndrome?
____

MEDICATION HISTORY

What medications are you currently taking? Please list:

Taking ______________________________________ For ______________________________________
Taking ______________________________________ For ______________________________________
Taking ______________________________________ For ______________________________________

What other medications have you taken over the last six months? ________________________________
____
____
____
____

NUTRITIONAL HISTORY

Please list any vitamins or minerals you regularly take. Specify amount (number of milligrams per day).

____

____

Do you usually eat:

Breakfast	YES	NO
Lunch	YES	NO
Dinner	YES	NO
Between Meals	YES	NO
Before Bed	YES	NO

Is your diet medically supervised? YES NO

Do you consume any of the following?

Milk	YES	NO	Coffee	YES	NO
Dairy Products	YES	NO	Tea	YES	NO
Chocolate	YES	NO	Artificial Sugar	YES	NO
Sweets	YES	NO	Soft Drinks	YES	NO
Refined Sugar	YES	NO	Tobacco	YES	NO
Alcohol	YES	NO	Beer	YES	NO
Wine	YES	NO	Red Meats	YES	NO
Fast Foods	YES	NO			

NOW PAST NO

Do you ever experience tingling or numbness in your hands or arms? Right? ____ Left? _____

Do you ever experience pain radiating down your arms? Right? _____ Left? ____

Do you awaken with an awareness of your tooth or jaws?

Do your jaw muscles frequently become tired, stiff, or painful? Right? _____ Left? _____

At the end of the day?

After sleep?

During eating?

Other activities? (Please specify) _________________________________

Does your face feel swollen? Where? ____________________________________

Do your jaw muscles ever feel excessively warm? Right? _____ Left? _____

NOW PAST NO

Do your teeth hurt from biting pressure? Right? _____ Left? _____

Have you ever had an adjustment of your bite, or your teeth ground on to improve your bite?

When was this done? ____

How many times? ____

Have you had orthodontic treatment?

Did you have full braces? _______ For how long? ___________________

How old were you when you started treatment? ____________________________

Did you have teeth removed as a part of the treatment? _____________________

Did you wear a retainer? ____________ For how long? _____________________

What was your orthodontist's name? ____________________________________

Do you feel your jaw is over-closed (your jaw closes too far)? _______________

Does your bite feel uncomfortable to you? How? __________________________

____

Are there times when you cannot get your back teeth together? _______________

Do you primarily chew on one side of your mouth? Right? _____ Left? _____

YES NO Are you presently in any dental pain? _______________________________________

YES NO Have you ever experienced any unfavorable reaction to dentistry? What? _________

____

YES NO Have you ever lost any teeth? From what cause? ______________________________

YES NO Have you ever had orthodontic treatment? See question on other form ____________

____

YES NO Do you have any growths or swellings in your mouth? How long have they existed?

____

YES NO Do you have any difficulty in swallowing? ____________________________________

YES NO Do your gums bleed when brushing your mouth? ______________________________

YES NO Do you avoid brushing any part of your mouth? Why? ________________________

YES NO Have you ever been told you have pyorrhea? When? ___________________________

YES NO Is any part of your mouth sensitive to temperature, pressure or food or drink? What?
____

YES NO Do you ever have a burning sensation in your mouth? __________________________

YES NO Have you ever had a bad reaction to a dental anesthetic? When? _________________

YES NO Does food catch between your teeth? _______________________________________

YES NO Do you have any pain or soreness around your eyes or ears or any other part of your face? When? ____

YES NO Are you aware of stiff neck muscles? How often? _____________________________

YES NO Do you ever awaken with an awareness of your teeth or jaws? __________________

YES NO Are you aware of clenching your teeth during daylight hours? How often?
____

YES NO Do you have difficulty in opening your mouth widely? _________________________

YES NO Are your jaws tired after a big meal? _______________________________________

YES NO Do you have ear pain? ____

YES NO Do you have ringing in the ears? ____

YES NO Do you have dizziness? ____

YES NO Does your mouth get dry? ____

YES NO Do you have "tension" headaches? How often? _______________________________

YES NO Do you have an unpleasant taste or odor in your mouth? _______________________

YES NO Are you satisfied with your teeth and appearance? _____________________________

YES NO Do you feel you will eventually wear full artificial dentures? ___________________

YES NO Do any members of your family, including your parents, wear dentures?
____

YES NO Are you deeply concerned about the finances required to return your mouth to excellent dental health? ____

YES NO Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? ____

HABIT PATTERNS

YES NO Do you sleep well? Explain ______________________________

____

1. Sleep Habits

Back	Stomach	With pillow
Side	Hand or arm under head	

2. Work Habits

Occupation ______________________________

Duties ______________________________

Sit? ____________________ Stand? ____________________

3. Hobbies/Recreation/ Sports Activities

____

____

4. Are you a singer? Yes No

If yes, explain: ______________________________

5. What musical instruments do you play? ______________________________

6. Do you exercise? Yes No

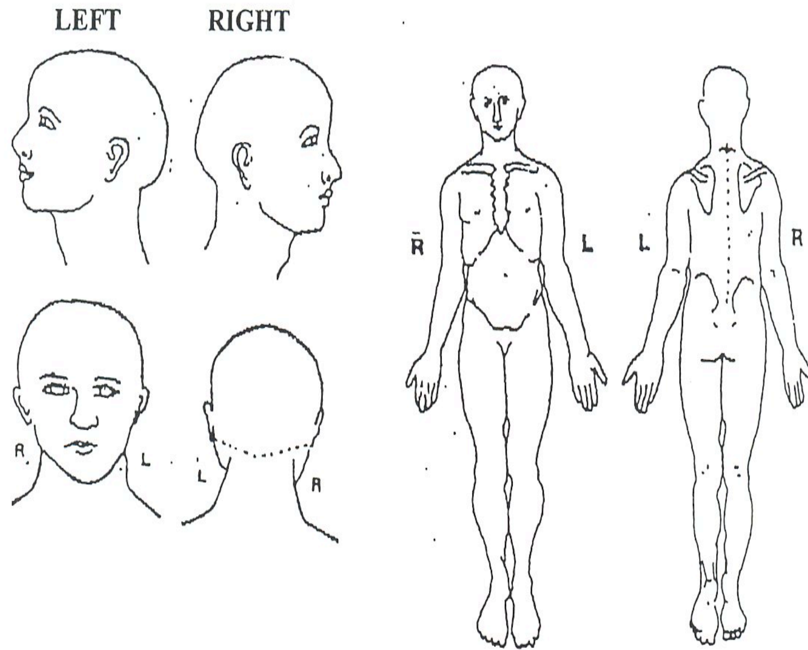
If yes, describe: ______________________________

SYMPTOM SURVEY

Instructions for completion: Please take time to accurately complete this survey. Your treatment success depends on this information. The description of items follows:

		Sign/Symptom	Location	Onset	Frequency	Intensity	Priority
		What are you experiencing?	R-Right Side L-Left Side B-Both Sides UML-Upper, Middle, Lower	When did you first notice this problem?	How often does it occur?	How intense is the problem? 1-Slight 2-Moderate 3-Severe	Note the three problems that bother you the most?
YES	NO	Headache	R L B	________	________	____	____
YES	NO	Facial Pain	R L B	________	________	____	____
YES	NO	Eye Pain	R L B	________	________	____	____
YES	NO	Ear Pain	R L B	________	________	____	____
YES	NO	T.M.J. Pain	R L B	________	________	____	____
YES	NO	Neck Pain	R L B	________	________	____	____
YES	NO	Shoulder Pain	R L B	________	________	____	____
YES	NO	Ringing in Ears	R L B	________	________	____	____
YES	NO	Fullness -Ears/Sinus	R L B	________	________	____	____
YES	NO	Numbness -Upper Limbs	R L B	________	________	____	____
YES	NO	Clicking/ Popping T.M.J.	R L B	________	________	____	____
YES	NO	Grating/ Grinding T.M.J.	R L B	________	________	____	____
YES	NO	Locked T.M.J.	R L B	________	________	____	____
YES	NO	Back Pain	U M L	________	________	____	____
YES	NO	Vertigo/ Dizziness	R L B	________	________	____	____
YES	NO	Difficulty Swallowing		________	________	____	____
YES	NO	Difficulty Closing Mouth		________	________	____	____
YES	NO	Difficulty Opening Mouth		________	________	____	____
YES	NO	Other ________		________	________	____	____
YES	NO	Other ________		________	________	____	____

Graphically depict the location and pattern of your pains on the following charts of head, neck, torso and limbs. Use small X's to show the area and patterns.



Do you feel that you are under a significant amount of emotional stress or tension? Yes No

How long have you had this? ____

Do you think you deal/dealt with this stress in a healthy way? ______________________

Please indicate anything else about yourself which you suspect may be related to your condition:

____

____

____

____

I, the undersigned (patient or legally responsible party); authorize treatment to be rendered, and assume financial responsibility. It is understood that models, radiographs, records and photographs taken in the examination and treatment remain the property of the doctor.

Signature ____ Date _______________

OFFICE POLICY ON FEES AND INSURANCE CLAIMS

Some insurance companies cover Temporomandibular Joint Dysfunction under the Dental or Major Medical portion of health insurance, but many do not.

Our patients must realize that professional services are rendered to the person and not the insurance company. The insurance company is responsible to you, the patient, and the patient is responsible to us. WE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT THE CHARGES WILL BE PAID BY AN INSURANCE COMPANY. If your company requests, we will write a letter to your insurance company explaining your Temporomandibular Joint problems.

Specific arrangements for the financial handling of your account must be made prior to the start of treatment. Please sign this policy form and we will enclose it in your file so there will be no misunderstanding regarding insurance.

Signed ____ Date __________________