Hobart Orofacial Pain and Special Needs Clinic

Orofacial Pain, TMJD, & OSA
Medical History Questionnaire

For all initial consultations, up to 1 hour is allowed for you and therefore it is important that you please take the time to complete **ALL** the following information prior to your appointment.

This form can take up to 30min and therefore if you have not completed it and brought it with you on arrival to your appointment, your consultation will most likely need to be rescheduled to another day.

Please **DO NOT** leave any section blank or unanswered even if you do not think the questions are relevant to your situation for which you are seeking treatment. For many people, apparently unrelated symptoms can be an underlying cause of another health condition.

If your appointment is the result of a workplace injury, or is being funded by a Third Party such as Workers Compensation Insurance, MAIB, or Victims of Crime, it is up to you to arrange all necessary approvals, referral letters, case manager details, and copies of any associated paperwork **PRIOR** to your appointment.

Due to current Privacy Laws, we unfortunately **CANNOT** arrange any of the above documentation on your behalf and we will need to reschedule your appointment if it is not available prior to (or at least on) the day of your appointment.

If you have had any xrays, sleep studies, or other diagnostic tests and investigations for your condition a copy of these may be required and brought with you to your appointment. We will advise and refer you for any other required xrays before your appointment.

PLEASE BRING THE COMPLETED DOCUMENT TO YOUR APPOINTMENT

Date: _____/_____/_____	Private Health Insurance: Number: Medicare Number:		Male ☐ Female ☐
Given Names Dr / Mr / Mrs / Ms / Miss			Date of Birth: _____/_____/_____ dd mm yy
Surname		Occupation:	
Contact Details	Home Phone: ( )	Business Phone: ( )	
	Mobile Phone:	Email:	
	Address:		Postcode:

Please provide the following information in **FULL**:

GP's First/Surname:	Practice Name:	Practice Address (incl Post Code):	Phone number:
Dentist's First/Surname:	Practice Name:	Practice Address (incl Post Code):	Phone number:

Please list all health practitioners (including Complementary Medicine) you have seen for your pain, jaw joint problem, snoring/sleep apnoea, and any back/neck/postural problems along with approximate dates and treatment performed: Example-

Dr Jones	Tympanic Road, Newstead 2021	ENT	Investigation of tinnitus	Oct 2001

Practitioner	Address	Speciality	Treatment	Approximate dates

GENERAL MEDICAL HISTORY

Have you had in the past 10 years or do you currently have any of the following conditions?

Please tick either 'Yes' or 'No'	Yes	No	Please tick either 'Yes' or 'No'	Yes	No
Anaphylaxis……..			Heart Palpations / Arrhythmias…		
Angina……			Heart Surgery……		
Anxiety / Depression……			Heart Valve Replacement……		
Asthma……			Hepatitis A / B / C……..		
Bleeding Disorder……			HIV / AIDS……		
Blood Pressure High / Low……			Insomnia……		
Blood Thinning Treatment……			Irritable Bowel Syndrome……		
Bruise Easily……..			Kidney Disease……		
Cancer……			Liver Jaundice		
Chemotherapy……			Lung Disease……		
Chronic Fatigue……			Nose Surgery……		
Cirrhosis of the Liver……			Osteoarthritis……		
Congestive Heart Failure……..			Osteoporosis……..		
Deep Vein Thrombosis……			Radiation Therapy……..		
Diabetes IDDM / NIDDM…….			Reflux……		
Drug Dependency……..			Rheumatic Fever……		
Elevated Cholesterol……..			Rheumatoid Arthritis……		
Emphysema……..			Sinus Surgery……..		
Endocarditis……..			Smoker 0-10 / 10-20 / >20 per day		
Epilepsy……..			Snoring / Sleep Apnoea		
Gastric / Peptic Ulcer……..			Stroke / Mini Stroke……..		
Hashimoto's Disease……..			Thrombocytopenia……		
Haemophilia……			Thyroid Problems……		
Heart Attack……..			Tonsils Removed……		
Heart Murmur……			Von Willebrand's Disease……..		
Heart Pacemaker……			Wisdom Teeth Extractions……..		

Please list any other medical conditions not listed above:

	Yes	No
Have you had lap band surgery?		
Have you used in the past any drugs recreationally? If yes, please list types and quantities (or years used)		

Do you consume alcohol? If yes, please list quantity per day or week	**Yes**	**No**

Medications List: Please provide a detailed list of ALL prescription and non-prescription medications you are currently taking and the doses e.g. Aspirin 100mg 1 tablet once a day, Endep 25mg 1 tablet once a day, etc including herbal medicines such as St John's Wort, Ginko Biloba, etc. Attach a separate list if required.

Medication	Dosage	Month / Year Started

ALLERGIES: Please list any allergies you may have including food and medications:

Medication	What happens?

CHIEF COMPLAINTS HISTORY

What are you seeking treatment for?_____

When did your condition(s) first occur?_____

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

____Motor vehicle accident ____Work related accident ____Other accident

____Stress ____Fall ____Illness ____Injury ____Other

If Other, please describe_____

If Accident, please date_____

HEAD, FACE, AND JAW JOINT HISTORY

Is there any childhood history of falls, accidents, or injury to the face or head? Yes No

Is there any recent injury to the face or head? Yes No

Have you ever suffered whiplash or an injury to the neck? Yes No When?_____

Is there any activity you do that holds your head or jaw in an unusual position for long periods of time? e.g. musical instrument playing, telephone sales, pencil chewing, scuba diving.

Yes No If Yes, please describe_____

Do you suffer from jaw pain? *(Please circle appropriate response)*

On opening or yawning?	Yes	No	Right	Left	Both
On closing?	Yes	No	Right	Left	Both
When chewing?	Yes	No	Right	Left	Both

Do you suffer from any of the following jaw symptoms? *(Please circle appropriate response)*

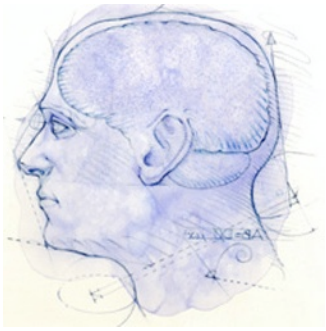
Clicking jaw?	Yes	No	Sometimes	Right	Left	Both
Jaw locking open?	Yes	No	Sometimes	Right	Left	Both
Jaw locking shut?	Yes	No	Sometimes	Right	Left	Both
Grating or grinding jaw noises?	Yes	No	Sometimes	Right	Left	Both
Limited opening?	Yes	No	Sometimes			

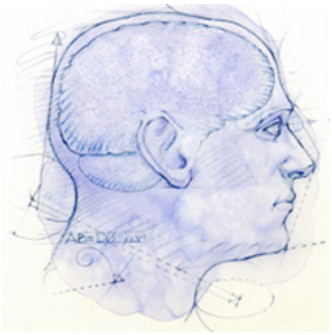
Are you aware of clenching or grinding your teeth during the day? Yes No Sometimes

HEADACHE HISTORY

Headaches: Using the diagram below, indicate the location of any headache you currently suffer from (even if headaches are irregular).

Left Side





Right Side

When did your headaches first begin to trouble you?_____

Typical duration of headaches:	seconds	minutes	hour's	days
Frequency of headaches:	daily	weekly	constant	
Severity of headaches:	mild	moderate	severe	
Description of headaches:	Tension	Crushing	Dull	Burning
Band-like Sharp	Tingling	Stinging	Other_____	

Do your headaches begin in the:	Morning	Afternoon	Evening	Whilst Asleep
Are your headaches worse in the:	Morning	Afternoon	Evening	Whilst Asleep
Does anything relieve your headache:	Yes	No	Sometimes	

Please describe_____

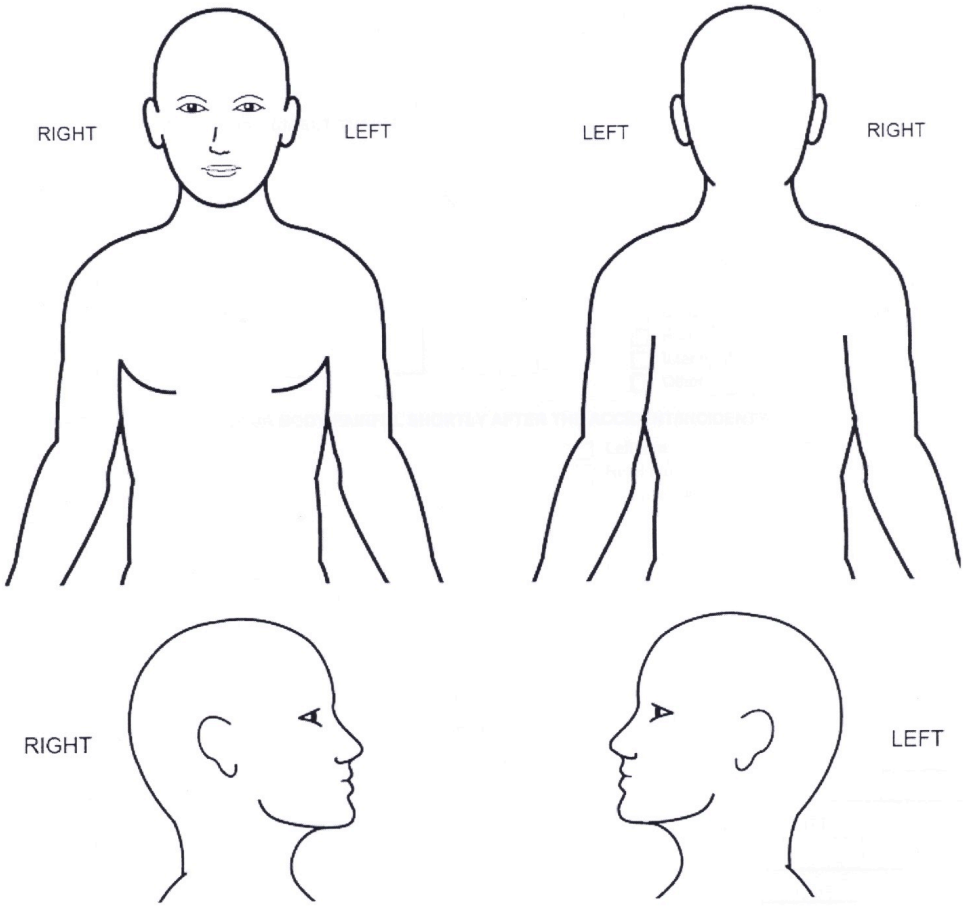
_____

CURRENT STRESS HISTORY

Please check each factor that applies to you and the month / year it first occurred or happened

- ❑ Death of spouse_____
- ❑ Pending marriage_____
- ❑ Marital separation_____
- ❑ Marital reconciliation_____
- ❑ Pregnancy / Childbirth_____
- ❑ Death of family member_____
- ❑ Moving House_____
- ❑ Major illness or injury_____
- ❑ Business adjustment_____
- ❑ Financial Problems_____
- ❑ Fired from work_____
- ❑ Career change_____
- ❑ Health problem_____
- ❑ Other_____

PAIN: Indicate by drawing or shading on the diagrams below the location and type of any pain you currently suffer from. Feel free to be as descriptive as you like.



What kind of things help ease the pain such as Passive: hot/cold packs, medications, rest, sleeping position, and Active: relaxation therapy, cognitive behavioural strategies, exercise?

_____

_____

_____

SNORING AND SLEEP APNOEA HISTORY

Do you have a history of snoring or obstructive sleep apnoea (OSA)? Yes No Sometimes Maybe

Have you ever had a sleep study performed on you? Yes No Date_____

What was the OSA diagnosis following the sleep study? Mild Moderate Severe

Do you ever wake up feeling as if you are choking or gasping? Yes No Sometimes

Have you ever received treatment for snoring or sleep apnoea? Yes No

What treatment did you receive? *(please circle)* CPAP Mouth Splint Diet / Exercise

Surgery - UPPP Rhinoplasty Stomach lap-banding Other_____

Were any of the treatments successful? Yes No Sort of

Please explain_____

If prescribed, are you still using your: CPAP Yes No **Mouth Splint** Yes No

If not, why not_____

Do you suffer from a Nasal Blockage? No Yes If yes: *Permanent* *Occasional*

Do decongestants help your nasal blockage? Yes No Sometimes

Indicate below	**Indicate below**	**Tick which symptoms & side-effects you suffer from:**
The frequency of your snoring or sleep apnoeic episodes? Constant ☐ Irregular ☐	What you believe is the severity of your snoring or sleep apnoea: Mild ☐ Moderate ☐ Severe ☐	_____Sore Throat _____Daytime Drowsiness _____Depression _____Waking Tiredness _____Irritability _____Loss of Libido _____Weight Gain _____Poor Memory _____Poor Concentration

In this section, describe your liklihood of falling asleep in the corresponding situations. Please tick				
Epworth Scale	Likelihood of falling asleep 0 = Never; 1 = Sometimes; 2 = Likely; 3 = Highly Likely			
	0	**1**	**2**	**3**
Sitting Reading				
Watching TV				
Sitting Inactive in Public Place				
Passenger in Car (1 hour)				
Lying Down Rest Afternoon				
Sitting Talking				
Sitting After Lunch (No Alcohol)				
Car While Stopped (3 minutes)				
	Total Score		**/ 24**	

Please Read and Sign Patient Declaration

MHQ – Medical History Questionairre
OSA – Obstructive Sleep Apnea
OAT – Oral Appliane Therapy

- I confirm that the details I have provided on Pages 1 to 7 inclusive of the attached **MHQ** are correct to the best of my knowledge.
- I understand that Dr Tony Eldridge is in a practice restricted solely to treating orofacial pain, TMJ disorders, oral medicine, oral surgery, and dental sleep medicine. Dr Eldridge has completed many post graduate courses and qualifications, and is a member of professional organisations that treat these conditions.
- I understand that Dr Tony Eldridge has no affiliation with any company, laboratory, or single appliance, and does not condone or recommend over the counter appliances to treat temporomandibular joint or snoring and sleep apnoea disorders.
- I will be examined and assessed and the diagnostic result and recommended treatment will be explained to me including all risks, benefits, time frames, and estimated costs before any treatment commences.
- If I suffer from snoring, I will be advised that my snoring may be a symptom of **OSA**.
- I will be advised that often, adjunctive treatment such as weight loss, diet, exercise, surgery, CPAP, referral to other specialists, allied health practitioners, or other treatments may be required to help my condition for which I am seeking treatment.
- I will be advised that referral to and treatment by other practitioners is not included in the cost of treatment with Dr Tony Eldridge.
- If I also suffer from **OSA**, I will be advised that sleep studies before and after commencement of **OAT** are required to properly manage my **OSA** condition.
- I understand that Mandibular Repositioning Devices, Oral Sleep Bruxism Applliances are mechanical aids which will only work while the appliance is worn.
- I understand that dental appliances do not last forever and require ongoing repair and maintenance including replacement at various intervals which is not included in the cost of treatment but will be completed at minimal laboratory costs after my intial treatment has been completed.
- I am aware that good oral hygiene is extremely important as the use of an oral appliance can exacerbate the formation of plaque and consequent decay.
- I will be advised that regular 6-12 monthly dental checkups with my general dentist are recommended to prolong the life of the appliance and to help minimise any dental complications such as decay and periodontal disease.
- I will be prior to treatment advised of the possible side effects of **OAT** and I undertake to contact the clinic promptly if I experience any unexpected side effects.
- I understand that some change to my bite position is theoretically possible and that this is an unavoidable consequence of treatment which must be balanced against the benefits of oral appliance therapy.
- I understand that a damaged joint in any part of my body will never be considered 'normal' again and that my temporomandibular joint is no exception.
- As with any medical or dental treatment, I understand that unusual occurrences can and do happen. These possibilities could include minor tooth movement, loosened teeth or dental restorations, a sore mouth, periodontal problems, muscle spasms, ear pain, or neck pain. Any of the mentioned complications are rare, but theoretically may occur.
- I understand that if I or any other practitiioner without prior consent makes adjustments to my oral appliance, all warranties are void and complications can occur.
- I understand that the purpose of treatment for TMJ disorders is to position the lower jaw either on the cartilage or in a position where my joint tissues will have a maximum chance of healing or regeneration. This is called '*progressive remodelling*' and may result in a change in the way my teeth and jaws meet and function. This stage of treatment usually takes 6-9 months to occur. Progressive remodelling is a sign of successful treatment but very often means the teeth no longer meet like they did before treatment began.
- I understand that failure by me not to attend recall visits when requested may lead to but is not limited to serious complications or side effects to my health, worn or broken appliances, a change in my bite position, or a relapse of my initial presenting symptoms.
- I have received, read, and understood the TMJD and OSA Patient Information Package either in print or on the internet at www.tmjtreatment.com.au
- I agree to pay all costs associated with any debt recovery that may occur in my name for any treatmentment that commences and remains as an outstanding account.
- I have read and understand this declaration and hereby elect to commence treatment.

Name_____ **Signature**_____ **Date**_____/_____/_____

Dr Tony Eldridge **Signature**  **Date**_____/_____/_____