

Hobart Orofacial Pain and Special Needs Clinic

Orofacial Pain & TMJD Medical History Questionnaire

It is important that you take the time to complete **ALL** the following information prior to your appointment. 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.

PLEASE BRING THE COMPLETED DOCUMENT TO YOUR APPOINTMENT

Date: ____/____/____	Private Health Insurance: _____ Medicare Number: _____	Number: _____	Male <input type="checkbox"/> Female <input type="checkbox"/>
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-

Practitioner	Address	Speciality	Treatment	Approximate dates
Dr Jones	Tympanic Road, Newstead 2021	ENT	Investigation of tinnitus	Oct 2001

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

Medication	Dosage	Month / Year Started

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

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

Do you: *(Please circle appropriate response)*

Clench your teeth? Yes No Sometimes

Grind your teeth? 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

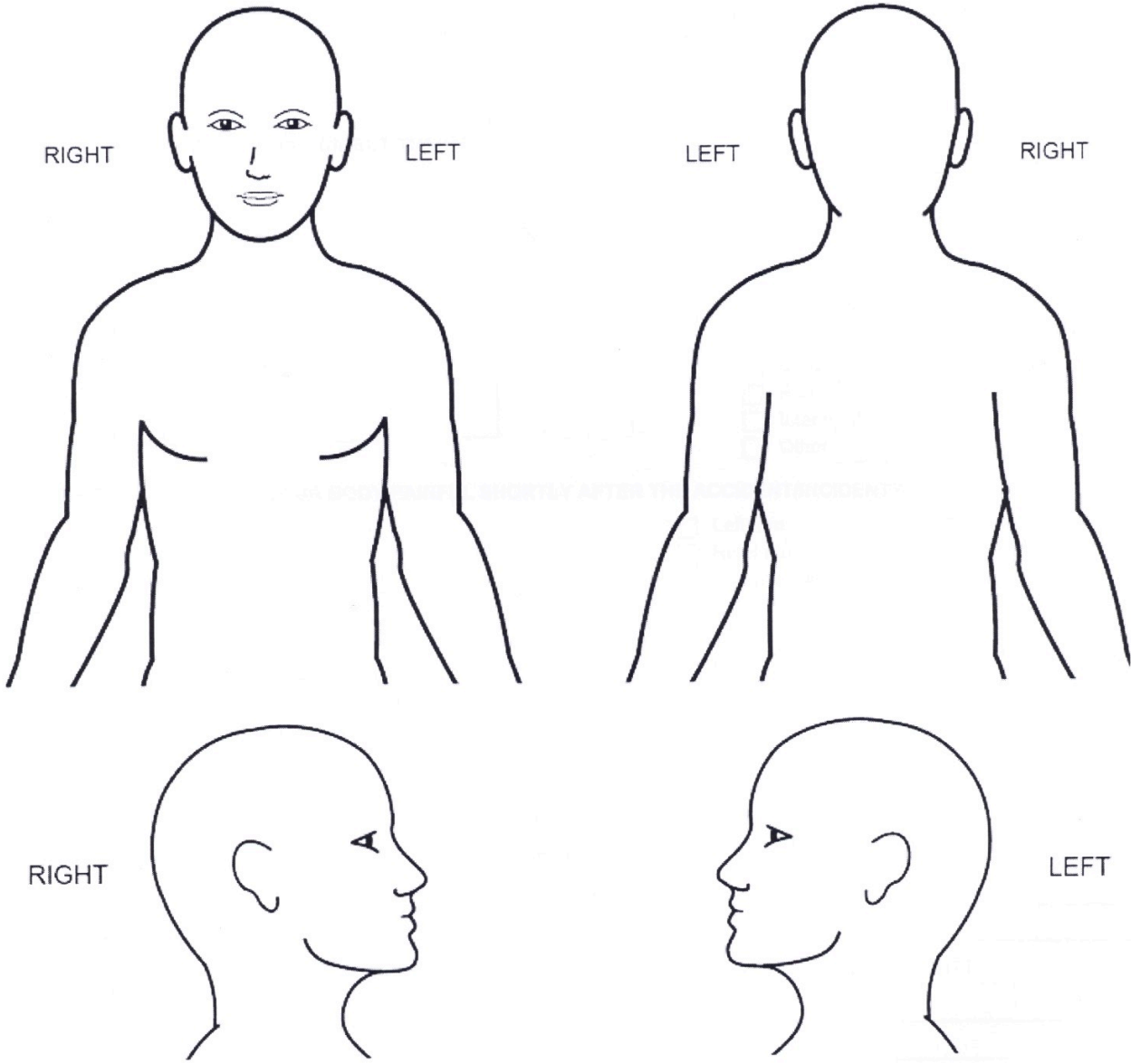
Please describe _____

CURRENT STRESS HISTORY

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

- | | |
|--|--|
| <input type="checkbox"/> Death of spouse _____
<input type="checkbox"/> Pending marriage _____
<input type="checkbox"/> Marital separation _____
<input type="checkbox"/> Marital reconciliation _____
<input type="checkbox"/> Pregnancy / Childbirth _____
<input type="checkbox"/> Death of family member _____
<input type="checkbox"/> Moving House _____ | <input type="checkbox"/> Major illness or injury _____
<input type="checkbox"/> Business adjustment _____
<input type="checkbox"/> Financial Problems _____
<input type="checkbox"/> Fired from work _____
<input type="checkbox"/> Career change _____
<input type="checkbox"/> Health problem _____
<input type="checkbox"/> 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 <input type="checkbox"/> Irregular <input type="checkbox"/>	What you believe is the severity of your snoring or sleep apnoea: Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	<input type="checkbox"/> Sore Throat <input type="checkbox"/> Daytime Drowsiness <input type="checkbox"/> Depression <input type="checkbox"/> Waking Tiredness <input type="checkbox"/> Irritability <input type="checkbox"/> Loss of Libido <input type="checkbox"/> Weight Gain <input type="checkbox"/> Poor Memory <input type="checkbox"/> Poor Concentration	

In this section, describe your likelihood of falling asleep in the corresponding situations.				
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 Questionnaire

OSA – Obstructive Sleep Apnea

OAT – Oral Appliance 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 a dentist with 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 have been or will be examined and assessed by a dentist and the diagnostic result and recommended treatment has been or will be explained to me including all risks, benefits, time frames, and estimated costs before any treatment commences.
- If I suffer from snoring, I have been or will be advised that my snoring may be a symptom of **OSA**.
- I have been or 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 have been or will be advised that referral to and treatment by other practitioners is not included in the cost of treatment with Dr Tony Eldridge and is to be borne by me.
- If I also suffer from **OSA**, I have been or 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 Appliances 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 initial 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 have been or 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.
- I have been or 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 the purpose of my treatment 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 Patient Information Package either in print or on the internet at www.tmj-treatment.com.au
- I agree to pay all costs associated with any debt recovery that may occur in my name for any treatment 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 ____/____/____