



Huntington Dental Excellence

Dr. Gin Goei

General Dentistry, Cranio-Mandibular Facial Pain/Esthetic Orthopedic Rehabilitation

Musculoskeletal Screening Questionnaire

| | |
|----------------------------|---------------------------|
| Name: | |
| Address: | |
| Date of Birth: / / | Today's Date: / / |
| Referred By: | |

One or more of the following symptoms may be indicative of Musculoskeletal Dysfunction of the head and neck. If you have any of the following symptoms, please indicate by circling the appropriate areas
L=Left R= Right

| | | | |
|---|--------------|--|--------------------------|
| Pain in jaw joints | L R | Headache | L R |
| Pain in ear | L R | Fullness, pressure blockage in ear | L R |
| Pain around eyes | L R | Pain in tongue | L R |
| Pain in lower jaw | L R | Partial inability to open mouth: | L R |
| Pain in upper jaw | L R | If yes, is it: 1) Constant | <input type="checkbox"/> |
| Pain in neck | L R | 2) Sporadic | <input type="checkbox"/> |
| Pain in shoulder | L R | Difficulty Chewing | __ Yes/No __ |
| Pain in forehead | L R | Difficulty swallowing | __ Yes/No __ |
| Pain in temples | L R | Loud snoring | __ Yes/No __ |
| Pain in facial muscles | L R | Constantly tired | __ Yes/No __ |
| Grating sound in joint | L R | Mouth breathes at night | __ Yes/No __ |
| Subjective hearing loss | L R | Awaken with a dry mouth | __ Yes/No __ |
| Clicking, snapping, or popping sound in joint underline which sounds most descriptive | L R | If yes: A) Frequently B) Rarely C) Never | |
| Dizziness (vertigo) | __ Yes/No __ | | |
| Upset stomach | __ Yes/No __ | | |
| Ringing in ears | L R | | |

What are your chief complaints? List from most to least important:

| |
|----|
| 1. |
| 2. |
| 3. |

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|-----------------|
| Other Symptoms: |
|-----------------|

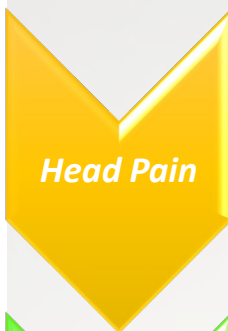

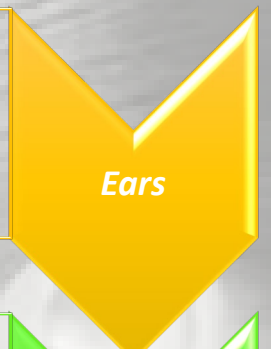
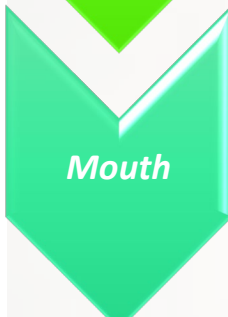

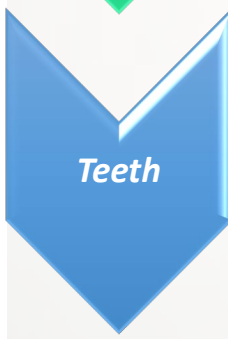
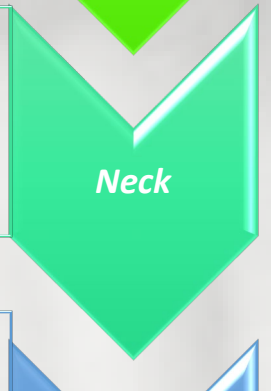
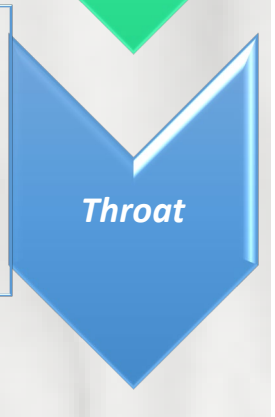
NAME: _____ D.O.B _____



| | | | |
|--|--|--------------------------------|-------------------------------|
| Do symptoms affect one or both jaw joints? | Left <input type="checkbox"/> | Right <input type="checkbox"/> | Both <input type="checkbox"/> |
| If both, indicate which joints seem most affected: | Left <input type="checkbox"/> | Right <input type="checkbox"/> | |
| How long have you been bothered by this problem? | Years ___ | Months ___ | Weeks ___ Days ___ |
| Have you had an injury to the jaw or face? | ___ Yes/No ___ | | |
| Do you have arthritis? | ___ Yes/No ___ | | |
| Have you ever had cervical traction? | ___ Yes/No ___ | | |
| Have you ever worn a neck brace? | ___ Yes/No ___ | | |
| Have you had any other treatment for this problem? If yes, please explain (medicine, dental appliance, night guard): | ___ Yes/No ___ | | |
| Have you ever had your teeth straightened (orthodontia)? | ___ Yes/No ___ | | |
| Have you had your teeth removed for orthodontia? | ___ Yes/No ___ | | |
| Have you ever had your wisdom teeth removed? | ___ Yes/No ___ | | |
| Have you ever had general anesthesia? | ___ Yes/No ___ | | |
| Did you have allergies as a child? | ___ Yes/No ___ | | |
| Have you had your bite adjusted by your dentist? (equilibration) If yes, please explain when: | ___ Yes/No ___ | | |
| Do you attribute the symptoms to any one accident? If yes, please explain: | ___ Yes/No ___ | | |
| Have you had cortisone injected into a joint? | ___ Yes/No ___ | | |
| If yes, when? | How many injections? _____ | | |
| By whom: | | | |
| Are you now on any medication? If yes, what kind and how much? | ___ Yes/No ___ | | |
| Do you know if you clench your teeth? | ___ Yes/No ___ | | |
| Has anyone mentioned that you grind your teeth at night during sleep? | ___ Yes/No ___ | | |
| Do you chew gum? | <input type="checkbox"/> Frequently <input type="checkbox"/> Infrequently <input type="checkbox"/> Moderately <input type="checkbox"/> Never | | |
| Please list chronologically names and types of doctors and their locations, whom you have seen in the past for this or related problems. | | | |
| Please write in any other pertinent information that has not been covered previously. | | | |
| Are you in litigation or are you planning litigation? ___ Yes/No ___ If so explain: | | | |

NAME: _____ D.O.B _____

Please take the time to check off any symptoms that applies to your condition. Please note if the symptom is present on the left (L), right (R) or both (B) sides of your head/ body.

| | | |
|--|--|--|
|  <p>Head Pain</p> | <input type="checkbox"/> Forehead R L B <input type="checkbox"/> Temples R L B <input type="checkbox"/> Migraine Type <input type="checkbox"/> Sinus type <input type="checkbox"/> Shooting pain up back of head <input type="checkbox"/> Hair and scalp painful to touch | |
|  <p>Eyes</p> | <input type="checkbox"/> Pain behind eye R L B <input type="checkbox"/> Bloodshot eyes R L B <input type="checkbox"/> Eyes bulging R L B <input type="checkbox"/> Sensitivity to sunlight R L B |  <p>Ears</p> <input type="checkbox"/> Hissing, buzzing, or ringing R L B <input type="checkbox"/> Decreased hearing R L B <input type="checkbox"/> Ear pain/ear ache no infection <input type="checkbox"/> Clogged "itchy" ears R L B |
|  <p>Mouth</p> | <input type="checkbox"/> Discomfort <input type="checkbox"/> Limited opening of mouth <input type="checkbox"/> Inability to open smoothly <input type="checkbox"/> Jaw deviates to one side when opening <input type="checkbox"/> Jaw locks shut or open <input type="checkbox"/> Can't find bite |  <p>Jaw</p> <input type="checkbox"/> Clicking, popping jaw joints R L B <input type="checkbox"/> Grating sounds R L B <input type="checkbox"/> Pain in cheek muscles R L B <input type="checkbox"/> Uncontrollable jaw or tongue movements |
|  <p>Teeth</p> | <input type="checkbox"/> Clinching, grinding at night <input type="checkbox"/> Looseness & soreness of back teeth |  <p>Neck</p> <input type="checkbox"/> Lack of mobility, stiffness R L B <input type="checkbox"/> Neck pain R L B <input type="checkbox"/> Tires sore muscles R L B <input type="checkbox"/> Shoulder aches & backaches <input type="checkbox"/> Arm numbness & or pain R L B <input type="checkbox"/> Finger numbness & or pain R L B |
| <p>Notes:</p> | |  <p>Throat</p> <input type="checkbox"/> Swallowing difficulties <input type="checkbox"/> Laryngitis <input type="checkbox"/> Sore throat with no infection <input type="checkbox"/> Voice irregularities or changes <input type="checkbox"/> Frequent coughing or clearing of throat <input type="checkbox"/> Feeling foreign object in throat constantly |