Top Down Dental
Los Gatos Dental Sleep Medicine
Nancy Nehawandian, DDS, MAGD

CONFIDENTIAL TMJ and SLEEP HISTORY

Name: **Date:**

Please Answer the following Questions

I. TMJ HISTORY

YES	NO	Do you have a burning or painful sensation in your mouth?
YES	NO	Do you get popping, clicking, or grinding noises when you open or close?
YES	NO	Do you ever awaken with an awareness of your teeth or jaws?
YES	NO	Are you aware of clenching during the daytime? How often?
YES	NO	Have you ever been told you grind your teeth during sleep?
YES	NO	Do you trouble opening your mouth widely?
YES	NO	Does your jaw ever lock open or closed? How often?
YES	NO	Do you feel your bite is different, unstable or uncomfortable?
YES	NO	Do you feel like your sense of balance has changed?
YES	NO	Do you have nasal congestion or difficulty breathing through your nose?
YES	NO	Have you been diagnosed with migraine or tension headaches?
YES	NO	Do you take Aspirin, Advil, Tylenol or another pain reliever? How often?

What professional advice or treatment have you had regarding your TMJ, headache or pain conditions/problems?

YES	NO	If you sought treatment for a TMJ problem, did it help?
YES	NO	Do you or have you had any pain in any of the following areas? (Circle)

Jaw Ear Face Neck Teeth Head Other

YES	NO	Do your jaw problems affect your ability to work?
YES	NO	Has your diet changed due to your jaw problems?
YES	NO	Do your joint noises affect others while eating?
YES	NO	Have you ever been injured in an accident? When?
YES	NO	Have you ever had a severe blow to your head? When?
YES	NO	Are you aware of stiff neck muscles? How often?
YES	NO	Have you ever been in traction for a neck injury? When?
YES	NO	Have you ever had or been advised to have neck surgery?
YES	NO	Have you ever been diagnosed with Trigeminal Neuralgia or Bell's Palsy?

II. FAMILY HISTORY

Have any members of your family (blood kin) had:

YES	NO	Heart Disease
YES	NO	High Blood Pressure
YES	NO	Diabetes
YES	NO	Sleep Apnea
YES	NO	TMJ Disorder

III. SOCIAL HISTORY

How often do you have an alcoholic drink?

Initial_____

Top Down Dental
Los Gatos Dental Sleep Medicine
Nancy Nehawandian, DDS, MAGD

How often do you take sedatives?

How often do you consume caffeine?

YES NO Do you smoke/use chewing tobacco? How much?

IV. SLEEP, SNORING AND APNEA HISTORY?

YES NO Have you been diagnosed or treated for a sleep disorder? When?

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

YES NO Do you have problems with insomnia?

YES NO Do you sleep well? How long?

YES NO Do you dream? How often?

YES NO Do you have trouble falling asleep or staying asleep? Which

YES NO Do you snore or have you been told you do?

YES NO Do you wake up with a headache?

YES NO Have you had chronic sleepiness, fatigue or weariness that you can't explain?

YES NO Do you often fall asleep reading or watching television?

YES NO Have you fallen asleep during the day against your will?

YES NO Have you had to pull off the road while driving due to sleepiness?

YES NO Have ever been more irritable and short tempered?

YES NO Have you felt that your memory and/or intellect are impaired?

YES NO Have you been told that you stop breathing while asleep?

About how many times per night do you wake up?

What time do you normally go to bed? Get up in the morning?

Of the hours you are in bed, about how many hours are you asleep?

Would you rate the quality of your sleep as □ Good □ Fair □ Poor

Present Body Weight? Height?

Have you ever had an evaluation at a sleep center? □ Y □ N Date:

What professional advice or treatment have you had regarding your snoring or sleep apnea?

V. Please Answer the following Questions

When did your symptoms first start?

Was there a specific incident, accident or injury that seemed to trigger your symptoms?

Do your present symptoms affect relationships with family and friends? If so, how?

What are your expectations in seeking treatment at this time?

Initial_____

What do you see yourself doing, after treatment that you are not able to do now?

Are you involved in a lawsuit regarding your condition? □ Y □ N

VI. WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Order: Please number the complaints with **#1** being the most important. (List all please)	**Frequency:** Please rate your chief complaint as follows: **1**=Occasional **2**=Frequent **3**=Constant	**Intensity**: Please rate your shief complaint on a scale from 0-10. **0**=No pain to **10**= Most severe pain

Chief Complaint	ORDER	Frequency (1-3)	Intensity (0-10)	For office use only
Jaw clicking/popping				
Jaw joint noise				
Jaw locking				
Muscle twitching				
Limited mouth opening				
Dizziness				
Generalized Headache (Entire head)				
Frontal Headache (Front of your head)				
Occipital Headache (Back of your head)				
Temporal Headache (In your temples)				
Visual disturbances/blurred vision				
Jaw pain				
Facial pain				
Ear pain				
Back pain				
Eye pain				
Neck pain				
Shoulder pain				
Pain when chewing				
Throat pain				
Ear congestion				
Sinus Congestion				
Ringing in the ears				
Fatigue				
Frequent heavy snoring				
Snoring which affecting sleep of others				

Initial_____

Top Down Dental
Los Gatos Dental Sleep Medicine
Nancy Nehawandian, DDS, MAGD

Significant daytime drowsiness				
Stop breathing when sleeping				
Difficulty falling sleep				
Gasping when waking up				
Nighttime choking spells				
Feeling un refreshed upon waking				
Morning hoarseness				
Swelling in ankles or feet				

VII. OTHER PROFESSIONALS

To better coordinate your treatment, please list the professionals you have consulted regarding your present symptoms. Please be sure to list primary physician and family dentist. Please initial if you want us to send them a report from your visit.

FAMILY PHYSICIAN

Name _____
Phone _____

DENTIST

Name _____
Phone _____

CHIROPRACTOR

Name _____
Phone _____

PHYSICAL THERAPIST

Name _____
Phone _____

EAR, NOSE AND THROAT

Name _____
Phone _____

CARDIOLOGIST

Name _____
Phone _____

ALLERGIST

Name _____
Phone _____

NEUROLOGIST

Name _____
Phone _____

PSYCHIATRIST

Name _____
Phone _____

PSYCHOLOGIST

Name _____
Phone _____

SLEEP SPECIALIST

Name _____
Phone _____

OTHER

Name _____
Phone _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE,

Patient /Guardian Signature: _____ ***Date:*** _____

Initial_____