FUNCTIONAL ORTHODONTIC DIAGNOSTIC QUESTIONNAIRE

Patient's Name _____
Birthdate _____/_____/_____ **Sex** _____
Patient's General Dentist _____
Occupation/School_____

Reason for presentation for evaluation and possible treatment: (check all that apply)

_____ **My dentist saw a problem**
_____ **A problem we have been aware of**
_____ **I / We actually don't see a problem**

Medical History: (please circle your answer)

Patient Overall Health **Good** **Fair** **Poor**
Is Patient Under Medical Treatment? **Yes** **No**
If yes, please specify the condition and treatment: _____
_____
Any Drugs or Medications? **Yes** **No**
Please List All Medication Currently Being Taken: _____
_____

Has The Patient Ever Had:

Abnormal Bleeding	**Yes**	**No**
Alcohol / Drug Abuse	**Yes**	**No**
Allergies (environmental / seasonal)	**Yes**	**No**
Allergies (to medicines)	**Yes**	**No**
Anemia	**Yes**	**No**
Arteriosclerosis	**Yes**	**No**
Arthritis	**Yes**	**No**
Artificial Bones / Joints / Valves	**Yes**	**No**
Asthma	**Yes**	**No**
Auto-immune Disorders	**Yes**	**No**
Birth Defects	**Yes**	**No**
Blood Disease	**Yes**	**No**
Blood Transfusion	**Yes**	**No**
Bruise Easily	**Yes**	**No**
Cancer / Chemotherapy	**Yes**	**No**
Diabetes	**Yes**	**No**
Difficulty Breathing	**Yes**	**No**

Dizziness / Fainting	**Yes**	**No**
Emotional Problems	**Yes**	**No**
Emphysema	**Yes**	**No**
Endocrine Problems	**Yes**	**No**
Epilepsy	**Yes**	**No**
Glaucoma	**Yes**	**No**
Head or Facial Traumatic Injury	**Yes**	**No**
Headaches Frequently	**Yes**	**No**
Hearing Disorders	**Yes**	**No**
Heart Attack / Surgery	**Yes**	**No**
Heart Murmur	**Yes**	**No**
Hepatitis	**Yes**	**No**
High or Low Blood Sugar	**Yes**	**No**
High or Low Blood Pressure	**Yes**	**No**
Intestinal Disorders	**Yes**	**No**
Kidney Problems	**Yes**	**No**
Liver Problems	**Yes**	**No**
Mitral Valve Prolapse	**Yes**	**No**
Nervous Disorder	**Yes**	**No**
Numbness of Arms or Hands	**Yes**	**No**
Pacemaker	**Yes**	**No**
Pneumonia	**Yes**	**No**
Rheumatic Fever	**Yes**	**No**
Swollen, Stiff, Painful Joints	**Yes**	**No**
Shortness of Breath	**Yes**	**No**
Tuberculosis	**Yes**	**No**
Ulcers	**Yes**	**No**

Explain any past hospitalizations, if any, or other Medical Problems:

_____

_____

Have Tonsils been removed? **Yes** **No** **What age?**_____
Have Adenoids been removed? **Yes** **No** **What age?**_____
Does the patient have a tendency to get:
- **Colds?** **Yes** **No**
- **Sore Throats?** **Yes** **No**
- **Ear Infections?** **Yes** **No**

Has the patient had (ventilation) Tubes placed in their ear(s)? **Yes** **No**

Oral History:

Has the patient ever sucked their thumb or finger(s)? **Yes** **No**
Has the patient acquired any speech problems? **Yes** **No**

Does the patient breathe through their mouth a significant amount of the time during the:

Daytime	**Yes**	**No**
Nighttime	**Yes**	**No**
Has the patient had previous orthodontic treatment?	**Yes**	**No**
Has either parent had previous orthodontic treatment?	**Yes**	**No**
Has / does the patient play a musical instrument?	**Yes**	**No**

If yes, what instrument(s)? _____

Have you consulted another dentist / orthodontist regarding the patient's orthodontic problem?	**Yes**	**No**

What is your chief concern with reference to the reason you want treatment done (the #1 problem that you want to make sure is "fixed" in treatment)? An example might be "I want the space between my front teeth closed". _____

_____

_____

Patient / Parent Signature_____

Date_____

TMJ AND AIRWAY EVALUATION

PAIN RELATED SYMPTOMS: (circle yes or no)

Do you get tension Headaches?	**Yes**	**No**
Do you get migraine Headaches?	**Yes**	**No**
Do you get headaches or tenderness in the temple areas?	**Yes**	**No**
Do you often have neckaches or stiff neck and / or shoulder muscles?	**Yes**	**No**
Have your teeth been sore upon awakening?	**Yes**	**No**
Does your jaw ache when you chew?	**Yes**	**No**
Do you, at times, have pain associated with your ear(s)?	**Yes**	**No**
Does your jaw ache when you open wide?	**Yes**	**No**
Do you have chronic back and / or shoulder pain?	**Yes**	**No**
Does either jaw joint give you pain?	**Yes**	**No**

When did the painful symptoms start? _____

_____

How often do you have the pain? _____

_____

Is the pain constant or intermittent? _____

_____

What time of night or day is the pain usually most severe?_____

_____

Do any of these activities cause discomfort /pain:

Yawning?	**Yes**	**No**
Chewing?	**Yes**	**No**
Swallowing?	**Yes**	**No**
Speaking?	**Yes**	**No**
Brushing teeth?	**Yes**	**No**
Turning your head?	**Yes**	**No**
Moving your neck?	**Yes**	**No**
Moving your shoulders?	**Yes**	**No**
Have you had any permanent teeth extracted?	**Yes**	**No**
Do you frequently need to use pain medication?	**Yes**	**No**

How often do you usually take medicine for the pain relief? _____

_____

What medication do you take? _____

_____

Have you consulted with, or had treatment from another doctor with regards to jaw joint pain, neck pain, back pain, headaches or related problems? Yes No

What was the doctor's name and phone number?

Dr's Name_____ Ph #_____

What was their diagnosis and treatment? _____

_____

_____

How effective was the treatment? _____

_____

_____

Did any treatment make you feel worse and how so? _____

_____

_____

_____

TRAUMA OR ACCIDENTS:

Have you ever had a severe blow to the head or jaw?	**Yes**	**No**
Ever had any whiplash neck injuries?	**Yes**	**No**
Ever been in a serious accident, such as a car accident?	**Yes**	**No**

ORAL / JAW JOINT SYMPTOMS OTHER THAN PAIN RELATED:

Are your jaws clenched / tired when you wake up?	**Yes**	**No**
Do you grind your teeth when asleep?	**Yes**	**No**
Do you hear or feel clicking or popping from either jaw joint?	**Yes**	**No**
Are your jaw muscles tense or tired frequently?	**Yes**	**No**

Do you have difficulty opening wide or yawning?	**Yes**	**No**
Do you feel or hear grating noises in your ears when you move your jaws?	**Yes**	**No**
Do you experience dizziness?	**Yes**	**No**
Do you ever feel faint?	**Yes**	**No**
Are there foods you avoid due to discomfort during eating?	**Yes**	**No**
Has your jaw ever locked open or closed?	**Yes**	**No**
Is there a family history of TMJ problems or headaches?	**Yes**	**No**

AIRWAY, EAR AND EYE SYMPTOMS:

Do you have allergies?	**Yes**	**No**
Is it difficult for you to breathe through your nose?	**Yes**	**No**
Do you frequently mouth breathe?	**Yes**	**No**
Do you have sinus problems?	**Yes**	**No**
Do you snore?	**Yes**	**No**
Do you have trouble sleeping soundly?	**Yes**	**No**
How many times a night do you wake up (interrupting sleep)?	**0 1 2 more**	
Do you feel rested and refreshed in the A.M after waking?	**Yes**	**No**
Are you tired and sleepy during the daytime frequently?	**Yes**	**No**
Have you been told you have Sleep Apnea?	**Yes**	**No**
Is your nose stuffed when you don't have a cold?	**Yes**	**No**
Do you frequently need to use anti-histamines or other decongestants?	**Yes**	**No**
Do you have any hearing loss?	**Yes**	**No**
Do you have itchiness or stuffiness in either ear?	**Yes**	**No**
Do you hear ringing, buzzing or hissing sounds in either ear?	**Yes**	**No**
Do you get pain in, around or behind either eye?	**Yes**	**No**
Are there times when your eyesight blurs?	**Yes**	**No**
Do you wear glasses or contacts?	**Yes**	**No**

Patient / Parent Signature_____

Date_____