Lane Eddleman, D.D.S.

Family & Cosmetic Dentistry

1606 Royal Avenue ~ Monroe, LA 71201 ~ 318-322-2013

TMJ/TMD

Temporomandibular Joint Disorder Patient Questionnaire & Information Form

In addition to our office registration and medical history form, please take some time and honestly answer this questionnaire in detail. Fully answering the questions should take a minimum of 30 minutes. Please remember that the more thorough and thoughtful the information you give us is, the more thorough our diagnosis can be.

Please return this form at least 2 days prior to your appointment.

Thank You,

Dr. Lane Eddleman & Staff

I. PERSONAL INFORMATION

Name: _____Date: _____Occupation: _____

Date of Birth: _____, Age: ___, Sex: ___, Race: _____, Height ___'___", Weight ____
Martial Status: ( ) Married, ( ) Remarried, ( ) Single, ( ) Divorced, ( ) Separated, ( ) Widowed
Please list the number and age of your children:

_____

Please list the number and age of anyone else living with you:

_____

Check the highest grade of schooling you have completed?
( ) less than high school ( ) high school ( ) vocational technical ( ) college ( ) graduate or professional
( ) other (describe) _____
Are you past or currently involved in a lawsuit concerning your jaw pain? YES NO

Who referred you to us? Name: _____ Phone # _____

Whom do you regard as your primary doctor? _____ Primary dentist? _____

II. CHIEF COMPLAINTS

Please write the reason(s) you are here. Begin with the worst one.

1. _____How long have you had this problem?_____

2. _____How long have you had this problem?_____

3. _____How long have you had this problem?_____

4. _____How long have you had this problem?_____

III. INFORMATION ABOUT YOUR PAIN

1. Please describe what event or events lead to your pain:

_____
_____
_____

2. Please indicate what you think is the cause of your pain.

_____
_____

3. Do you have any clicking/popping in your jaw (if so, what side? And does it make any noise?)?

_____

Have you had any clicking/popping in your jaw in the past that is no longer present today? (please describe) _____

Does, or has, your jaw ever locked Open or Closed (please describe)? _____
_____

How often does your pain occur?

___once or twice a day ___continuously (nonstop)
___several times a day ___several times a week ___less than 3-4 times per month
___once or twice a month ___less than once a month

4. How has the ***intensity*** of the pain changed throughout the time you have had it?
____increased ____decreased ____stayed the same

5. If you have pain-free periods, how long do they last!
____minutes, ____hours, ____days, ____weeks, ____months

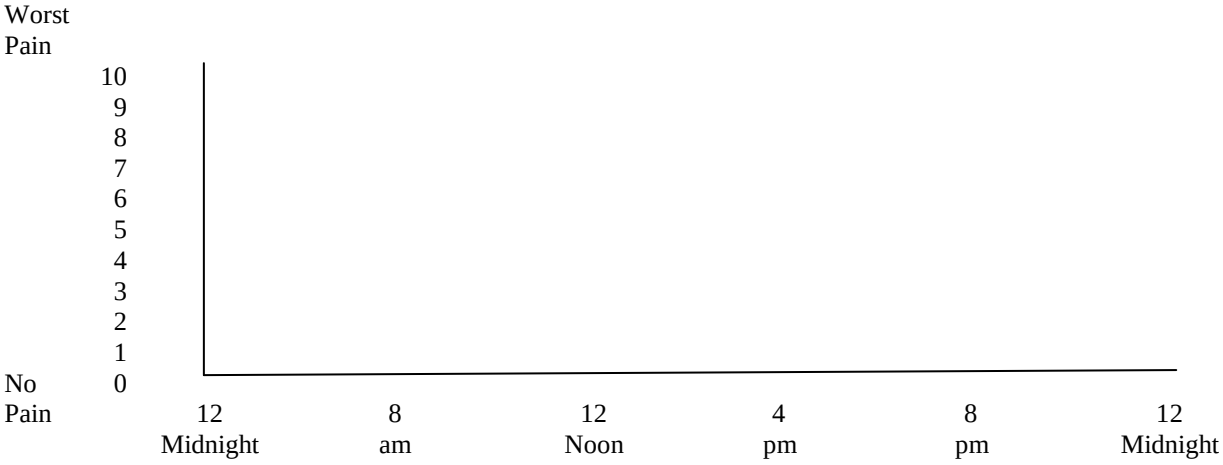
6. Describe the circumstances of your last pain-free period of 3 or more days, if you have had one:_____
_____
_____

7. Which of the following affect your pain?
Mark "B" for better, "W" for worse, and leave blank for "no effect".
__heat __ cold __sitting __massage or rubbing __walking __running
__standing __lying down __coughing __fatigue __straining __getting out of bed
__vibration __anxiety __noise __sudden movements __wet climate __hot climate
__cold climate __alcohol __caffeinated drinks (coffee, tea, colas) __work
__strong emotion (anger, excitement, surprise, etc.)
__other _____
__particular movements (explain) _____

8. The following scale represents pains of increasing intensity. Would you please mark on the scale the intensity of your pain right now by placing an "N", the intensity of your pain at it's worst by placing a "W", and the intensity of your pain at it's least by placing an "L".

No Pain ——————————— The Worst Pain Ever

9. Please draw a line on the graph below to show us how *YOUR* pain changes through the day. If it does not change, draw a straight line at the approximate pain level.



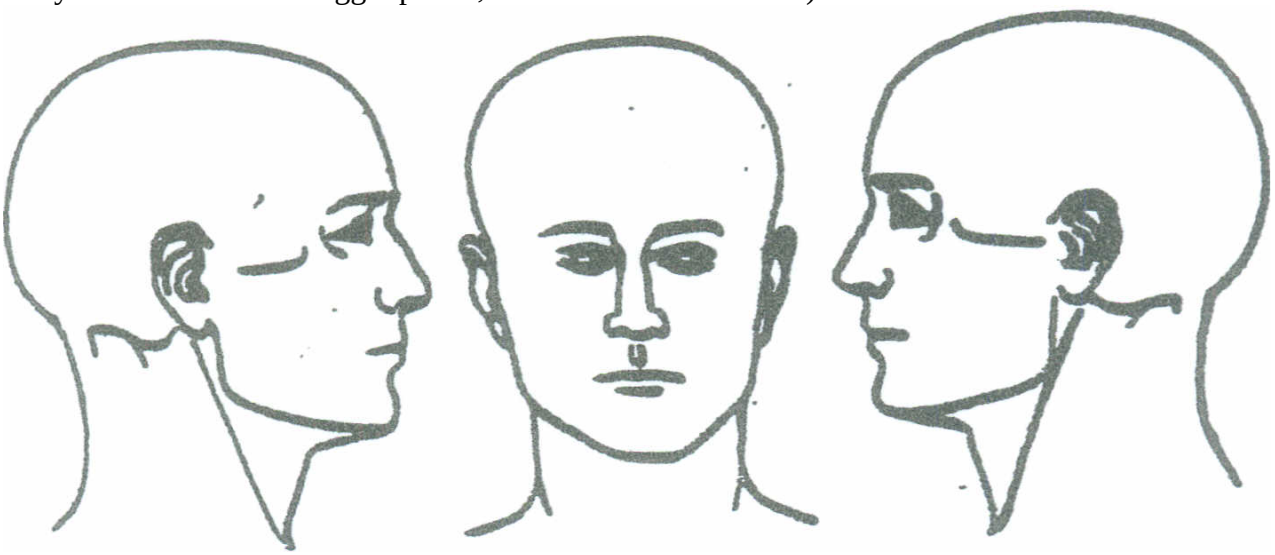
10. Please draw a line on the graph below to show us how *YOUR* pain changes through the entire period of time since it began.

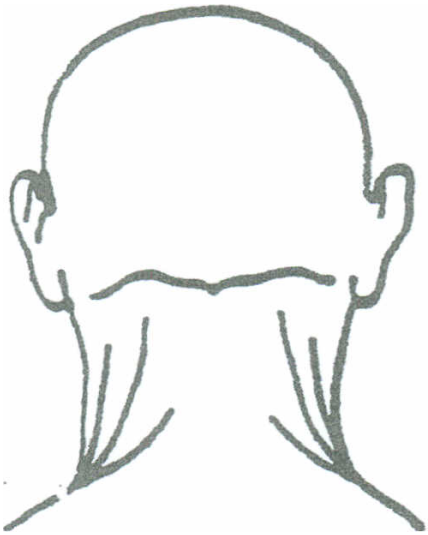
11. Please list all the medications that you are taking now (attach list if pre-prepared).

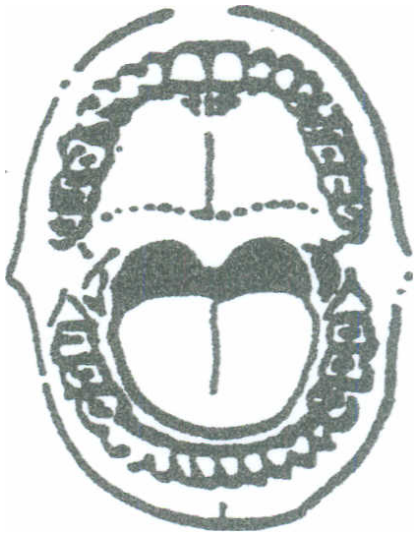
Drug	*Strength*	*# pills per day*	*Taking Since*

12. LOCATION OF YOUR PAIN

Using these pictures, indicate which parts of your head and neck are affected by pain by shading them with a pen or a pencil. (If you have more than one: use a different color for each. If you have any particularly sensitive areas or trigger points, label them with an "X".)







If you have pains in other areas of your body that are not in these pictures please list them here:

_____

_____

13. QUALITY OF THE PAIN

A. In your own words, describe what your pain feels like.

_____

_____

_____

B. Some of the words below may describe your present pain. Circle only one in each of the 20 groups, if the group contains a word that describes your pain. Leave out any group that is not suitable.

1	2	3	4	5	6	7
Flickering	Jumping	Pricking	Sharp	Pinching	Tugging	Hot
Quivering	Hashing	Boring	Cutting	Pressing	Pulling	Burning
Pulsing	Shooting	Drilling	Lacerating	Gnawing	Wrenching	Scalding
Throbbing	Shocking	Stabbing		Cramping		Searing
Beating		Lancinating		Crushing		
Pounding						

8	9	10	11	12	13	14
Tingling	Dull	Tender	Tiring	Sickening	Fearful	Punishing
Itchy	Sore	Taut	Exhausting	Suffocating	Frightful	Grueling
Smarting	Hurting	Rasping			Terrifying	Cruel
Stinging	Aching	Splitting				Vicious
Heavy						Killing

15	16	17	18	19	20
Wretched	Annoying	Spreading	Tight	Cool	Nagging
Blinding	Troublesome	Radiating	Numb	Cold	Nauseating
	Miserable	Penetrating	Drawing	Freezing	Agonizing
	Intense	Piercing	Squeezing	Icy	Dreadful
	Unbearable		Tearing		Torturing

14. EFFECT OF PAIN ON ACTIVITY
Please describe how your pain interferes with your daily activities at work or at home.

_____
_____
_____

15. EFFECT OF PAIN ON SLEEP
A. Do you have trouble going to sleep? _____
B. Do you have trouble staying asleep? _____

IV. PAST MEDICAL HISTORY

1. What other medical problem(s) do you have now?

_____
_____
_____

2. Please list all operations and hospitalizations you have bad and the dates (include tonsillectomy, appendectomy and hysterectomy, if applicable).

_____
_____
_____

3. Do you currently or have you ever had significant emotional problems? _____
_____
_____

4 Do you smoke? YES / NO If YES, how much _____

5 Please indicate the number of cups/glasses/cans you drink of the following each day.
coffee_____ tea_____ cola_____

6 Do you drink alcohol? YES I NO If YES, how much per day_____

V. YOUR MOOD & FUNCTIONING

For each item circle the number which best fits how you feel.

		1 Strongly agree	2 agree somewhat	3 disagree somewhat	4 strongly disagree
1.	I worry a lot.	1	2	3	4
2.	I feel hopeful-about the future.	1	2	3	4
3.	1'm frequently irritable.	1	2	3	4
4.	I enjoy doing things as much as ever.	1	2	3	4
5.	I sleep as well as ever.	1	2	3	4
6.	I often feel depressed.	1	2	3	4
7.	I often feel nervous or fearful.	1	2	3	4
8.	I have lots of energy.	1	2	3	4
9.	My memory and concentration seem fine.	1	2	3	4
10.	My appetite has changed.	1	2	3	4
11.	My weight has not changed much over the past. couple of months.	1	2	3	4
12.	I feel like I have little control over much of what happens to me.	1	2	3	4
13.	I have much to be angry about.	1	2	3	4
14.	I don I t feel like doing many of the things I used to enjoy.	1	2	3	4
15.	I often feel guilty.	1	2	3	4
16.	I feel like there are people in my life I can truly count on for support.	1	2	3	4
17.	1'm under a lot of stress at this time.	1	2	3	4
18.	I feel I'm lucky in life.	1	2	3	4

VI. SOME DENTAL QUESTIONS

1. Have you ever had any trauma to the head or neck? YES / NO
   If yes, please give the year and some detail about the trauma.

_____

_____

_____

2. Have you ever had any occlusal splints (bite planes, night guards, etc.)? YES / NO

3. Have you ever had any "occlusal equilibration- of the teeth? YES / NO
   (Grinding on the enamel to make the teeth fit better).

4. Have you ever had any orthodontic treatment? YES / NO
   (Straightening the teeth with braces or removable appliances)

5. Do you keep your teeth together most or all of the time? YES / NO
   (do you clench or grind you teeth together?) DAY / NIGHT

6. On which side do you chew your food? RIGHT / LEFT / BOTH

VII. FINALLY!

1. Is there any information not requested on this questionnaire that you think might be important or relevant to your case? If so, please use this space to give us your thoughts.

_____

_____

_____

_____

_____

2. RELEASE OF INFORMATION
May we release the information on this questionnaire to the referring dentist or physician and other doctors participating in your care? YES / NO
If yes, please sign and date:

Signature: _____

Date: _____