OCCLUSAL REHABILITATION CENTRE

BITE, TMJ, HEAD AND NECK PROBLEM MANAGEMENT

Dr. Abbas Tejani & Dr. John Nasedkin

Welcome! Jaw and bite problems, and related mouth and facial symptoms, are very difficult to diagnose. They frequently arise from more than one causative factor even though it may appear to have occurred because of a specific incident or injury. For this reason we ask you to complete this questionnaire in full. Many of the questions involve some detail, and may not appear relevant to you, but please answer them. This information will be held confidential and only communicated to those of your choice.

OCCLUSAL/TM JOINT AND ORO-FACIAL PATIENT INFORMATION:

Full Name: Prefer to be called:

Street Address: City: Postal Code:

Occupation: Employer:

Business Address (w/ postal code):

Telephone Numbers (w/ area code) Home: Office:

Fax: Cell:

Email address: Preferred Contact Method:

Date of Birth: Age: Gender:

Marital status: Spouse's name: (or parents' if minor)

Do you have children? Boys Ages: Girls Ages:

Emergency Contact: Contact Number: Relationship:

Are you a member of a dental plan? If yes, please bring your plan card or booklet with you.

Referred by: Reason:

What is your chief complaint? _____

Are you in pain at the moment? If yes, where is the pain?

When did you first notice the problem?

Please list the doctors or health practitioners (and indicate their specialty) whom you have consulted for your bite problem. Use the back of the last page of this series if needed.

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MEDICAL HISTORY:

Physician's name: Phone: Address:

Phone Number: Postal Code:

Do you have tension headaches? Yes No Migraine headaches? Yes No

How many migraines or headaches do you have per week?

Describe your general health? Poor Fair Good

Do you have low back pain? Yes No

Do you have difficulty sitting for prolonged periods? Yes No

Were you a difficult or forceps delivery at birth? Yes No

Have you recently lost weight unintentionally with good appetite? Yes No

Do injuries or cuts take longer to heal than previously Yes No

Is there a history of diabetes in your family? Yes No

Do you suffer from hypoglycemia or low blood sugar? Yes No

Do you urinate 6+ times a day? Yes No Do you wear glasses? Yes No

Are you thirsty most of the time? Yes No Do you wear contact lenses? Yes No

Have you had any eye trouble recently? Yes No Do you have arthritis? Yes No

Do you have ulcers or colitis? Yes No Do you have psoriasis? Yes No

Do you have acid reflux (heartburn)? Yes No

Do you wear a cardiac pacemaker? Yes No Are you pregnant/nursing? Yes No

Are you bulimic? Yes No Are you double-jointed? Yes No

Have you had hepatitis/jaundice? Yes No Do you have gout? Yes No

Do you experience tingling, numbness or pain in your arms, fingers or hands? Yes No

Have you ever been told you have one leg shorter than the other? Which? Yes No

Do you wear arch supports in your shoes? Yes No

Have you ever had any of the following? (circle which)Heart disease; Heart attack; Heart defect; Stroke; Rheumatic fever; Scarlet Fever; High blood pressure;Fainting spells; Convulsions or seizures; Brain tumor; Headaches when lying down; Swelling of ankles or feet Cold hands or feet; Shortness of breath without exercise; Nervous breakdown or psychotherapy; Aids/Tested HIV+; Lung trouble (TB, asthma, emphysema, COPD); Hormonal disorder; Tight feeling in chest; VD (includes herpes); Joint Replacement or implant; NONE.

Stress and Tension:

Are you on a regular exercise program? Yes No Describe the activity:

When was your last vacation? Do you drive a lot? Yes No

Has there been a recent change in your lifestyle such as a change in marital status, childbirth, change of employment, death in the immediate family or other stressful events? If so, what? Yes No

Medications:
Please list the names and doses of all the medications you are taking at present. Be sure to include even those only occasionally taken and birth control or hormone therapy pills if female.

Have you become sick from, shown an allergy to, or been told NOT to take any drugs or medications?
Yes No Which?

Do you have skin reactions to jewelry or irritation between your fingers or on your wrists or forearms?
Yes No

Have you ever been told you require pre-medication prior to an invasive procedure? Yes No

Have you ever had an unusual reaction to dental anesthesia (gas or injection)? Yes No

Have you had injections of steroids such as cortisone? Yes No

Have you had a recent operation for which a general anesthetic was required? Yes No

Diet and Nutrition:
What meal did you last eat? Consisting of:

Are you on a prescribed diet? Yes No Describe:

Please list the names and doses of all *nutritional supplements* you are taking at present. Include occasional.

Do you smoke? Yes No If so, what _____

Do you drink coffee? Yes No How many cups per day?

Do you have more than one alcoholic drink per day? Yes No

Ears, Nose and Throat:

Do you have difficulty breathing through the nose? Yes No

Have difficulties with your sense of smell? Yes No Do you have difficulty swallowing? Yes No

Have problems with taste perception? Yes No Do you sleep with your mouth open? Yes No

Do you snore or stop breathing at night Yes No

Are you sleepy during the day? Yes No

Do you sleep on your right side, left side or back? (circle one)

Do you experience earaches? Yes No Which side?

Do you hear sounds or fullness in your ears? Yes No Any hearing loss? Yes No

Do you have excessive wax in your ears? Yes No Suffer from dizziness? Yes No

Do you have sinus infections? Yes No Have post-nasal drip? Yes No

Chewing System:

Have you been hit in or fallen on your jaw? Yes No If so, when?

Have you been involved in a car accident? Yes No If so, when?

Do you swim vigorously or competitively? Yes No Do you scuba dive? Yes No

Do you hold the phone on your shoulder? Yes No Which shoulder?

Do you play a musical instrument? Yes No If so, which?

Do you sing? Yes No Do you eat quickly or slowly?

Do you play with your lips? Yes No Do you bite your nails? Yes No

Do you chew gum? Yes No

Are you in the habit of keeping anything between your teeth? Yes No

Do you feel that your bite is over-closed? Yes No

Do your jaw muscles tire frequently? Yes No

Do you hear clicking or popping sounds in your jaw joint? Yes No

Do you hear gravel-like or grating sounds in your jaw joint? Yes No

Do you have problems in opening your mouth widely? Yes No

Are you aware of clenching or clamping your teeth? Yes No

Have you ever been told that you grind your teeth at night? Yes No

Do you awaken with awareness of your teeth or jaws? Yes No

Do you have sore or sensitive teeth? Yes No Which side do you chew on?

Does the jaw problem interfere with your work or activities? Yes No

Dental History:

Dentist's Name: Practice Name:

Practice Phone Number: Practice Address:

Last visit to Dentist: Reason:

Have you had x-rays or a CT scan of your jaw joints? Yes No If yes, where/when?

Have you had orthodontic treatment? Yes No

Have you had your wisdom teeth removed? Yes No

Have you had periodontal (gum) treatment? Yes No

Do you have root canals? Yes No If yes, How many ?

Do you have extensive crowns and bridges? Yes No

Have you had your bite adjusted? Yes No If yes, where and when?

Do you wear a removable denture, night guard or bite splint? Yes No

Do you have any missing back teeth which have not been replaced? Yes No

When your lips are at rest, do your teeth touch? Yes No

Have you ever had virus ulcers or cold sores on your face or inside of mouth? Yes No

Do you have a dry mouth? Yes No Do you have a burning tongue? Yes No

Has your saliva changed in amount or taste? Yes No

Have you ever had your teeth whitened? Yes No If so, where?

If so, how often do you whiten? When was the last time?

General:

Please describe any other specific or general information which may not have been asked but which your dentists should know.

Have you prepared a narrative report of your symptoms, consultations, treatment and similarly related history as per the letter provided to you upon booking your appointment? *(required)* Yes No

Any comments or questions you might have? You will receive an informative pamphlet about jaw joint disorders and any hand-outs which we feel are appropriate for your understanding.

You will receive a copy of your report and we will send a copy to those whom you indicate below. *You are welcome to photocopy your report for others involved in your care.*

I would like a copy of my report sent to the following: (email addresses and postal codes are essential).

_____

CONSENT:

I, _____ hereby give The Occlusal Rehabilitation Centre and all healthcare professionals working under that entity consent to treatment and will not hold these bodies responsible for the outcome of such treatment with the understanding that treating doctors and healthcare professional will practice within their scope of practice as set forth by the College of Dental Surgeons and within the guidelines of their respective professional governing authorities.

I, _____ do hereby consent to the release of dental and medical information,
PRINT NAME
including clinical records and x-rays relative to my health care to Dr. John Nasedkin, or Dr. Abbas Tejani, Occlusal Rehabilitation Centre, Vancouver, to be faxed or sent upon the faxed request for same.

I also consent to copies of my record being sent to other health care professions to whom I am referred or recommended by Dr. John Nasedkin and Dr. Abbas Tejani as advised to me in writing or in person.

Date:_____ Signature:_____
Your e-mail return of this form when completed constitutes a signature above.

Thank you,

Dr. Abbas Tejani, BDS (Bristol) Fellow of The American Academy of Craniofacial Pain.(A.A.C.P.), Diplomate, America Board of Craniofacial Sleep Medicine. (DABCDSM)
Dr. John Nasedkin, DDS, FRCD(C)
And the care team at the **Occlusal Rehab Centre**