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:	
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.

2408 West 41st Avenue
Vancouver, BC V6M 2A4

604-687-3740 TEL
604-568-3714 FAX

www.occlusalrehab.com
occlusalrehab@gmail.com

MEDICAL HISTORY:

Physician's name: Address:

Phone Number: Postal Code:

Describe your general health? Poor Fair Good

Following injuries or dental treatment, do you have bleeding problems?				Yes	No
Do injuries or cuts take longer to heal than previously				Yes	No
Were you a difficult or forceps delivery at birth?				Yes	No
Have you recently lost weight unintentionally with good appetite?				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 wear a cardiac pacemaker?	Yes	No	Are you pregnant/nursing?	Yes	No
Do you have low back pain?	Yes	No	Are you double-jointed?	Yes	No
Have you had hepatitis/jaundice?	Yes	No	Do you have gout?	Yes	No
Do you have difficulty sitting for prolonged periods?				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

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

How many migraines or headaches do you have per week?

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: Cigarettes? Yes No Pipe? Yes No Cigars? Yes No

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:

Have difficulty breathing through the nose? Yes No

Have difficulties with your sense of smell? Yes No

Have problems with taste perception?	Yes	No	Have difficulty swallowing?	Yes	No
Do you sleep with your mouth open?	Yes	No	Do you snore?	Yes	No
Do you have difficulty breathing at night?	Yes	No	Suffer from insomnia?	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 chew gum?	Yes	No	Do you scuba dive?	Yes	No
Do you hold the phone on your shoulder?	Yes	No	Which shoulder?		
Do you engage in open-mouthed projection?	Yes	No	Do you sing?	Yes	No
Do you swim vigorously or competitively?	Yes	No	Do you eat quickly or slowly?		
Do you play a musical instrument?	Yes	No	If so, which?		
Do you play with your lips?	Yes	No	Do you bite your nails?	Yes	No
Do you bite have other mouth-related habits?					
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
Do you feel that your bite is over-closed?				Yes	No
Does the jaw problem interfere with your work or activities?				Yes	No

DENTAL HISTORY:

Dentist's Name: Practice Name:

Practice Phone Number: Practice Address:

Practice Postal Code:

Last visit to Dentist: Reason:

Have you had your wisdom teeth removed? Yes No

Have you had orthodontic treatment? Yes No

Have you had periodontal (gum) treatment? Yes No

Do you have extensive crowns and bridges? Yes No

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

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

Do you wear a removable denture, nightguard 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

Are you in the habit of keeping anything between your teeth? 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

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

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

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?

Do you plan to have any whitening done in the foreseeable future? Yes No

Do you want to change anything else about your smile in the foreseeable future? Yes No

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 also 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 two copies to those whom you have indicated. *You are welcome to photocopy your report for others involved in your care.*

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

CONSENT:

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.

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

Thank you,

Dr. John Nasedkin, DDS, FRCD(C)
Dr. Abbas Tejani, BDS (Bristol)
And the staff at the **Occlusal Rehab Centre**