

## HEADACHE AND FACIAL PAIN SCREENING QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Temporomandibular Disorders are a frequent cause of headaches, facial pain and dental pain.  
Please complete this screening questionnaire.

**SYMPTOM CHECKLIST:** Please check any of the following symptoms that apply to you. (L=left and R=right)

Headaches:

\_\_\_\_\_ Migraines                      \_\_\_\_\_ Tension Headaches                      \_\_\_\_\_ Other \_\_\_\_\_

How Often? \_\_\_\_\_

Top of Head	_____ L	_____ R	Temples	_____ L	_____ R
Forehead	_____ L	_____ R	Behind Eyes	_____ L	_____ R
Back of Head	_____ L	_____ R	Pain in Shoulder	_____ L	_____ R
Pain in Ear	_____ L	_____ R	Tinnitus (Ringing in Ears)	_____ L	_____ R
Dizziness (vertigo)	_____ L	_____ R	Facial Pain (Non-specific)	_____ L	_____ R
Pain in Jaw Joint	_____ L	_____ R	Grating sound in joint	_____ L	_____ R

Clicking or popping in jaw joint    \_\_\_\_\_ L                      \_\_\_\_\_ R

Partial inability to open mouth    \_\_\_\_\_ No                      \_\_\_\_\_ Yes                      \_\_\_\_\_ Constant                      \_\_\_\_\_ Sporadic

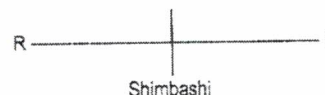
Difficulty chewing                      \_\_\_\_\_ No                      \_\_\_\_\_ Yes

Have you ever worn braces                      \_\_\_\_\_ No                      \_\_\_\_\_ Yes

Age when braces were on                      \_\_\_\_\_

Orthodontist                      \_\_\_\_\_

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### SLEEP APNEA EVALUATION

We have seen a recent increase in sleep apnea findings in our patients, which is a life threatening medical problem. To protect your health, we are asking you to complete the following screening form.

PLEASE ANSWER:

Do you snore?    \_\_\_\_\_ No                      \_\_\_\_\_ Yes

Are you excessively tired during the day?                      \_\_\_\_\_ No                      \_\_\_\_\_ Yes

Have you been told you stop breathing during sleep?                      \_\_\_\_\_ No                      \_\_\_\_\_ Yes

Do you have a history of hypertension?                      \_\_\_\_\_ No                      \_\_\_\_\_ Yes

Is your neck size greater than....

17 inches (male)	_____ No	_____ Yes
15 inches (female)	_____ No	_____ Yes

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$$\text{BMI} = \frac{W}{H^2(in.)} \times 703 = \underline{\hspace{2cm}}$$

### MALLAMPATI

I    II    III    IV

Tonsils:    Absent    Present

Adenoids: Absent    Present

YES to two or more of these questions is a positive screen to sleep apnea. If you answered yes to two or more questions, show this completed questionnaire to your doctor.