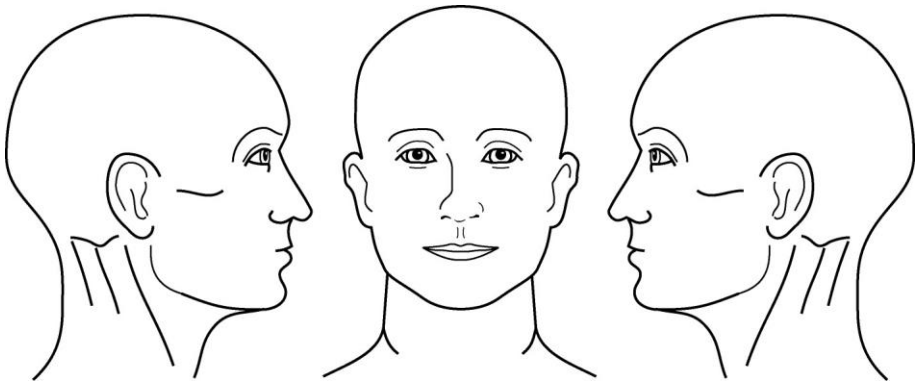
Dan P. Hilton, D.D.S. Initial Patient Questionnaire

Name: _____ Date: _____

1. On the diagram below, please shade the areas of your pain:

Right Left



2. When did your pain/problem begin? __

3. What seemed to cause it to start? _____
   _____

4. What makes it feel worse? ____
   _____
   Does it worsen when eating, talking, yawning, clenching your teeth, etc.? Yes ___ No ___

5. What makes it feel better? ____

6. What treatments have you received? __
   _____

7. When is your pain the worst?
   When first wake up ___ Later in the day ___ No daily pattern ___ Other ___

8. What does the pain keep you from doing? ____

9. Is your pain (check as many as apply):
   Ache ___ Pressure ___ Dull ___ Sharp ___ Throbbing ___ Burning ___ Other ___

10. Does your pain:
    Wake you up at night? Yes ___ No ___
    Increase when you lie down? Yes ___ No ___
    Increase when you bend forward? Yes ___ No ___
    Increase when you drink hot or cold beverages? Yes ___ No___
11. Please circle the number below to indicate your present pain level.

    (No pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (The worst pain imaginable)

12. Please circle your average pain level during the past 6 months.

    (No pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (The worst pain imaginable)

13. Is your pain always present? Yes ___ No ___ How often do you have it? _ _____

14. Please describe any symptoms other than pain that you associate with your problem.
    _____

15. Have you had:
    Yes ___ No ___ Head or neck surgery?
    Yes ___ No ___ Whiplash or trauma to your head or neck? Yes
    ___ No ___ Shingles on your head or neck?

16. Do you have:
    Yes ___ No ___ A fever?
    Yes ___ No ___ Nasal congestion or stuffiness?
    Yes ___ No ___ Movement difficulties of your facial muscles, eyes, mouth or tongue?
    Yes ___ No ___ Numbness or tingling?
    Yes ___ No ___ Problems with your teeth?
    Yes ___ No ___ Swelling over your jaw joint or in your mouth or throat?
    Yes ___ No ___ A certain spot that triggers your pain?
    Yes ___ No ___ Recurrent swelling or tenderness of joints other than in your jaw joint?
    Yes ___ No ___ Morning stiffness in your body, other than with your jaw?
    Yes ___ No ___ Muscle tenderness in your body (other than in your head or neck) for more than 50% of the time?

17. Is your problem worse:
    Yes ___ No ___ when swallowing or turning your head? Yes
    ___ No ___ after reading or straining your eyes?

18. Do your jaw joints make noise? Yes ___ No ___ If yes, which: Right ___ Left ___

19. Have you ever been unable to open your mouth wide? Yes ___ No ___ If yes, please explain: _

20. Have you ever been unable to close your mouth? Yes ___ No ___ If yes, please explain: _____

21. Do you sleep well at night? Yes ___ No ___ Please explain: _____ _____
22. How often are you overwhelmed, tense, aggravated or frustrated during a usual day? Always ___ Half the time ___ Seldom ___ Never ___

23. How often do you feel depressed during a usual day? Always ___ Half the time ___ Seldom ___ Never ___

24. Do you have thoughts of hurting yourself or committing suicide? Yes ___ No ___

25. Do you play a musical instrument and/or sing more than 5 hours in a typical week? Yes ___ No ___

26. What percent of the day are your teeth touching? ____ %

27. Are you aware of clenching or grinding your teeth: when sleeping? ___ while driving? ___ when using a computer? ___ other times? ___ not aware? ___

28. Are you aware of oral habits such as: chewing your cheeks? ___ chewing objects? ___ biting your nails or cuticles? ___ thrusting your jaw? ___ other habits? ___ not aware? ___

29. What treatment do you think is needed for your problem? ___ _____

30. Is there anything else you think we should know about your problem? _____ _____

31. If your age is 50 or older, please circle the correct response:
    Yes ___ No ___ Does your pain occur only when you eat?
    Yes ___ No ___ Are you pain free when you open wide?
    Yes ___ No ___ Do you have unexplainable scalp tenderness?
    Yes ___ No ___ Are you experiencing unexplainable or unintentional weight loss?
    Yes ___ No ___ Do you have significant morning stiffness lasting more than ½ hour? Yes ___ No ___ Do you have visual symptoms or a visual loss?

To the best of my knowledge the above information is correct and I give permission for a written report to be sent to my referring and treating doctors and dentists.

_____ _____

Signature Date