doolin · haddad
ADVANCED DENTISTRY

433 W. University Dr.
Rochester, MI 48307
www.rochesteradvanceddentistry.com
+1 248 656-2020

MUSCULOSKELETAL SCREENING QUESTIONNAIRE

DATE _____ **DATE OF BIRTH**_____

NAME _____

One or more of the following symptoms may be indicative of Musculoskeletal Dysfunction of the head and neck. If you have any of the following symptoms, please indicate by cicling the appropriate letters and, if appropriate, marking left or right. (L = Left R = Right)

a. Pain in jaw joints ___ L R ___
b. Pain in ear ___ L R ___
c. Pain around eyes ___ L R ___
d. Pain in lower jaw ___ L R ___
e. Pain in upper jaw ___ L R ___
f. Pain in neck ___ L R ___
g. Pain in shoulder ___ L R ___
h. Pain in forehead ___ L R ___
i. Pain in temples ___ L R ___
j. Pain in facial muscles ___ L R ___
k. Grating sound in joint ___ L R ___
l. Subjective hearing loss ___ L R ___
m. Clicking, snapping, or popping sound in joint underline which sounds most descriptive.)
If present, is it in ___L R ___
n. Dizziness (vertigo) ___Yes No ___
o. Upset stomach-nausea ___Yes No ___
p. Ringing sound in ears ___L R ___
q. Headache ___L R ___
r. Fullness, pressure blockage in ear ___L R ___
s. Pain in tongue ___L R___
t. Partial inability to open mouth ___L R___
If yes, is it (1) Constant ___
(2) Sporadic ___
u. Difficulty chewing ___Yes No___
v. Difficulty swallowing ___Yes No___
w. Loud snoring ___Yes No___
x. Constantly tired ___Yes No___
y. Mouth breathe at night ___Yes No___
z. Awaken with a dry mouth ___Yes No___
If yes, a) Frequently _____
b) Rarely _____
c) Never _____

1. What are your chief concerns? List from most to least important.

_____
_____
_____
_____

2. Have you had your teeth straightened (orthodontics)? Yes ___ No___

3. Have you had teeth removed for orthodontics? Yes ___ No___

4. Have you had your wisdom teeth removed? Yes ___ No___

5. Have you ever had general anesthesia? Yes ___ No___

6. Have previous dentists had difficulty getting you numb? Yes ___ No___

7. Did you have allergies as a child? Unknown ___ Yes___

8. Has your bite been adjusted by your dentist? Yes ___ No___
   If yes, please explain and when _____

9. Have you had your tonsils and/or adenoids removed? Yes ___ No___

10. Are you now on any medications? Yes___ No___
    If yes, what kind and how much?
    _____
    _____
    _____

11. Do you know if you clench your teeth? Yes___ No___

12. Do you know if you grind your teeth? Yes___ No___

13. Have you ever been told that you grind your teeth at night while sleeping? Yes___ No___

14. Do you chew gum?
    Frequently ___ Moderately ___ Infrequently ___ Never ___

15. Have you ever been involved in an accident or injury (including: sports injury, serious slips or falls, ski accidents, etc?)
    _____

    When? _____

    What happened? _____

_____

16. Please list chronologically; names and types of doctors and their locations, whom you have seen in the past for any dentally or medically, related problems.

    a. _____

    b. _____

    c. _____

    d. _____

    e. _____

17. Please write in any other pertinent information that has not been covered previously.

_____

_____

_____

_____

Patient Signature _____ ***Date*** _____

Doctor Name _____ ***Date*** _____

Address _____ ***City*** _____ ***Zip*** _____

Telephone _____