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Restorative - Cosmetic - Neuromuscular  
Dentistry

MUSCULOSKELETAL SCREENING QUESTIONNAIRE

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Referred by \_\_\_\_\_

Chief Complaint \_\_\_\_\_

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 checking the appropriate areas (L = left, R = right).

- |  |           |   |           |
|--|-----------|---|-----------|
| a. Pain in jaw joints                            | ___L R___ | s. Pain in tongue                                 | ___Y N___ |
| b. Pain in ear                                   | ___L R___ | t. Partial inability to open mouth. If yes, is it | ___Y N___ |
| c. Pain around eyes                              | ___L R___ | (1) constant                                      | ___       |
| d. Pain in lower jaw                             | ___L R___ | (2) sporadic                                      | ___       |
| e. Pain in upper jaw                             | ___L R___ | u. Difficulty chewing                             | ___Y N___ |
| f. Pain in neck                                  | ___L R___ | v. Difficulty swallowing                          | ___Y N___ |
| g. Pain in shoulder                              | ___L R___ | w. Loud snoring                                   | ___Y N___ |
| h. Pain in forehead                              | ___L R___ | x. Constantly tired                               | ___Y N___ |
| i. Pain in temples                               | ___L R___ | y. Mouth breathe at night                         | ___Y N___ |
| j. Pain in facial muscles                        | ___L R___ | z. Awaken with a dry mouth                        | ___Y N___ |
| k. Grating sound in joint                        | ___L R___ | If yes, a) Frequently ( )                         |           |
| l. Subjective hearing loss                       | ___L R___ | b) Rarely ( )                                     |           |
| m. Clicking, snapping, or Popping sound in joint | ___L R___ |   |           |
| n. Dizziness (vertigo)                           | ___Y N___ |   |           |
| o. Upset stomach, nausea                         | ___Y N___ |   |           |
| p. Ringing sound in ears                         | ___L R___ |   |           |
| q. Headache                                      | ___L R___ |   |           |
| r. Fullness, pressure, blockage in ear           | ___L R___ |   |           |

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

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

Other symptoms (please write in) \_\_\_\_\_

2. Do symptoms affect one or both joints? Right\_\_\_\_\_ Left\_\_\_\_\_ Both\_\_\_\_\_

If both joints, which joint seems most affected Right\_\_\_\_\_ Left\_\_\_\_\_

3. How many years, months, weeks or days have you been bothered by this problem?

a. \_\_\_\_\_years b. \_\_\_\_\_months c. \_\_\_\_\_weeks d. \_\_\_\_\_days

4. Have you had any injury to the jaw or face? \_\_\_\_\_Y N\_\_\_\_\_

5. Do you have arthritis? \_\_\_\_\_Y N\_\_\_\_\_

6. Have you ever had cervical traction? \_\_\_\_\_Y N\_\_\_\_\_

7. Have you ever worn a neck brace? \_\_\_\_\_Y N\_\_\_\_\_

8. Have you ever had any other treatment for this problem? \_\_\_\_\_Y N\_\_\_\_\_

If yes, explain (ie: medicine, exercise, dental appliances, etc.). \_\_\_\_\_

\_\_\_\_\_

9. Have you ever had your teeth straightened (orthodontia)? \_\_\_\_\_Y N\_\_\_\_\_

10. Have you had teeth removed for orthodontia? \_\_\_\_\_Y N\_\_\_\_\_

11. Have you had your wisdom teeth removed? \_\_\_\_\_Y N\_\_\_\_\_

12. Have you ever had general anesthesia? \_\_\_\_\_Y N\_\_\_\_\_

13. Did you have allergies as a child? unknown \_\_\_\_\_Y N\_\_\_\_\_

14. Have you had your bite adjusted by a dentist (equilibration)? \_\_\_\_\_Y N\_\_\_\_\_

If yes, please explain \_\_\_\_\_

15. Do you attribute your symptoms to any one incident? \_\_\_\_\_Y N\_\_\_\_\_

If yes, please explain \_\_\_\_\_

16. Have you had cortisone injected into your jaw joint? \_\_\_\_\_Y N\_\_\_\_\_

If yes, when? \_\_\_\_\_ By whom? \_\_\_\_\_

How many injections? \_\_\_\_\_

17. Are you now on any medications? \_\_\_\_\_Y N\_\_\_\_\_

If yes, what kind and how much? \_\_\_\_\_

18. Do you know if you clench your teeth? \_\_\_\_\_Y N\_\_\_\_\_

19. Has anyone told you that you grind your teeth (brux) at night during sleep? \_\_\_\_\_ Y N \_\_\_\_\_

20. Do you chew gum?      Frequently ( )      Infrequently ( )  
   Moderately ( )      Never ( )

21. Please list chronologically, names and types of doctors and their locations, which you have seen in the past for or related problems. Write on back of this sheet if necessary.

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

22. Is there any other pertinent information that has not been discussed? Write on back of this sheet if necessary.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

23. Are you in litigation or are you planning litigation related to your dental condition? \_\_\_\_\_ Y N \_\_\_\_\_

If so, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Patient's signature