Huntington Dental Excellence
Dr. Gin Goei
General Dentistry, Cranio-Mandibular Facial Pain/Esthetic Orthopedic Rehabilitation

Musculoskeletal Screening Questionnaire

Name:	
Address:	
Date of Birth: / /	Today's Date: / /
Referred By:	

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 circling the appropriate areas L=Left R= Right

Pain in jaw joints	**L R**	**Headache**	**L R**
Pain in ear	**L R**	**Fullness, pressure blockage in ear**	**L R**
Pain around eyes	**L R**	**Pain in tongue**	**L R**
Pain in lower jaw	**L R**	**Partial inability to open mouth:**	**L R**
Pain in upper jaw	**L R**	**If yes, is it: 1) Constant**	☐
Pain in neck	**L R**	**2) Sporadic**	☐
Pain in shoulder	**L R**	**Difficulty Chewing**	**__Yes/No___**
Pain in forehead	**L R**	**Difficulty swallowing**	**__Yes/No___**
Pain in temples	**L R**	**Loud snoring**	**__Yes/No___**
Pain in facial muscles	**L R**	**Constantly tired**	**__Yes/No___**
Grating sound in joint	**L R**	**Mouth breathes at night**	**__Yes/No___**
Subjective hearing loss	**L R**	**Awaken with a dry mouth**	**__Yes/No___**
Clicking, snapping, or popping sound in joint underline which sounds most descriptive	**L R**	**If yes: A) Frequently B) Rarely C) Never**	
Dizziness (vertigo)	**__Yes/No___**		
Upset stomach	**__Yes/No___**		
Ringing in ears	**L R**		

What are your chief complaints? List from most to least important:
1.
2.
3.
Other Symptoms:

Do symptoms affect one or both jaw joints?	**Left ☐ Right ☐ Both ☐**
If both, indicate which joints seem most affected:	**Left ☐ Right ☐**
How long have you been bothered by this problem?	**Years____ Months ____ Weeks ____ Days ____**
Have you had an injury to the jaw or face?	**__Yes/No___**
Do you have arthritis?	**__Yes/No___**
Have you ever had cervical traction?	**__Yes/No___**
Have you ever worn a neck brace?	**__Yes/No___**
Have you had any other treatment for this problem? **If yes, please explain (medicine, dental appliance, night guard):**	**__Yes/No___**
Have you ever had your teeth straightened (orthodontia)?	**__Yes/No___**
Have you had your teeth removed for orthodontia?	**__Yes/No___**
Have you ever had your wisdom teeth removed?	**__Yes/No___**
Have you ever had general anesthesia?	**__Yes/No___**
Did you have allergies as a child?	**__Yes/No___**
Have you had your bite adjusted by your dentist? (equilibration) **If yes, please explain when:**	**__Yes/No___**
Do you attribute the symptoms to any one accident? **If yes, please explain:**	**__Yes/No___**
Have you had cortisone injected into a joint?	**__Yes/No___**
If yes, when?	**How many injections? ___________**
By whom:	
Are you now on any medication? **If yes, what kind and how much?**	**__Yes/No___**
Do you know if you clench your teeth?	**__Yes/No___**
Has anyone mentioned that you grind your teeth at night during sleep?	**__Yes/No___**
Do you chew gum?	**☐ Frequently ☐ Infrequently ☐ Moderately ☐ Never**
Please list chronologically names and types of doctors and their locations, whom you have seen in the past for this or related problems.	
Please write in any other pertinent information that has not been covered previously.	
Are you in litigation or are you planning litigation? ____Yes/No____ If so explain:	

NAME:____D.O.B_____________

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Please take the time to check off any symptoms that applies to your condition. Please note if the symptom is present on the left (L), right (R) or both (B) sides of your head/ body.

Head Pain

- ☐*Forehead* *R L B*
- ☐*Temples* *R L B*
- ☐*Migraine Type*
- ☐*Sinus type*
- ☐*Shooting pain up back of head*
- ☐*Hair and scalp painful to touch*

Eyes

- ☐*Pain behind eye* *R L B*
- ☐*Bloodshot eyes* *R L B*
- ☐*Eyes bulging* *R L B*
- ☐*Sensitivity to sunlight* *R L B*

Mouth

- ☐*Discomfort*
- ☐*Limited opening of mouth*
- ☐*inability to open smoothly*
- ☐*Jaw deviates to one side when opening*
- ☐*Jaw locks shut or open*
- ☐*Can't find bite*

Teeth

- ☐*Clinching, grinding at night*
- ☐*Looseness & soreness of back teeth*

Notes:

Ears

- ☐*Hissing, buzzing, or ringing* *R L B*
- ☐*Decreased hearing* *R L B*
- ☐*Ear pain/ear ache no infection*
- ☐*Clogged "itchy" ears* *R L B*

Jaw

- ☐*Clicking, popping jaw joints* *R L B*
- ☐*Grating sounds* *R L B*
- ☐*Pain in cheek muscles* *R L B*
- ☐*Uncontrollable jaw or tongue movements*

Neck

- ☐*Lack of mobility, stiffness* *R L B*
- ☐*Neck pain* *R L B*
- ☐*Tires sore muscles* *R L B*
- ☐*Shoulder aches & backaches*
- ☐*Arm numbness & or pain* *R L B*
- ☐*Finger numbness & or pain* *R L B*

Throat

- ☐*Swallowing difficulties*
- ☐*Laryngitis*
- ☐*Sore throat with no infection*
- ☐*Voice irregularities or changes*
- ☐*Frequent coughing or clearing of throat*
- ☐*Feeling foreign object in throat constantly*

NAME:____________________________________**D.O.B**____________