TMJ & Sleep Apnea Center

Platinum Dental, Inc.

New Patient Questionnaire

Patient Name: _____ Date: _____

1. What is the main reason for your visit with our office today?

2. How has your problem impacted your life or lifestyle?

3. How did you find out about your problem?

4. What treatments/therapies have you already had for this problem?

5. If you have had treatments or therapies for your problem, how effective were they in your judgment? (If multiple types of therapies, rate each separately)
   A. Very effective B. Effective C. Somewhat effective D. Not at all effective
   E. comments:_____

_____

_____

_____

_____

Continued …

6. Have you had a "sleep study" performed either in a sleep lab or at your home?
   Yes No ☐ Lab ☐ Home☐ ☐
   A. If yes, what is the date of the sleep study? _____
   B. Have you had a follow-up sleep study? _____

7. Check any of the following symptoms you are experiencing or have experienced in the past:
   ☐ jaw pain ☐ clicking/popping jaw joints ☐ headaches
   ☐ ear pain ☐ ringing in ear ☐ neck pain/shoulder pain/back pain
   ☐ difficulty/pain on chewing/swallowing
   comments: _____

8. Do you wear dentures or other removable appliances in your mouth?
   ☐ No ☐ Yes :_____
9. Have you seen any other health care provider for this problem?
   A. No B. Yes; (If yes, what type of health care provider?)
   A. Dentist B. Medical doctor C. Sleep Specialist D. ENT specialist
   E. Others:_____

10. How energetic are you upon waking up in the morning?
    ☐ Full of energy ☐ Normal ☐ Sluggish ☐ Tired

11. Do you snore? ☐ Yes ☐ No

12. Do you have high blood pressure or other cardiovascular disease?
    ☐ Yes ☐ No ☐ Don't know
13. How many hours of sleep do you get per night on average?

14. Do you work during the day or night?

15. How many times a night do you get up to use the restroom?