Patient Questionnaire

Name: ______________________________

Date: _______________________________

Please take your time to answer these questions as completely as possible. Your answers will help obtain approval from your insurance company if surgery is necessary. Please feel free to use the bottom of page two if you need more room.

Please circle yes (Y) or no (N) where appropriate and explain in the room provided.

Do you have difficulty chewing foods? Y N Examples: ____________________________

Do you have difficulty biting into foods? Y N Examples: ___________________________

Are you only able to use certain teeth to chew? Y N Which ones? ___________________

Do you have difficulty swallowing? Y N

Do you get indigestion from not chewing well? Y N

Please describe any problems you have eating: ____

____

____

Do you have facial pain while eating? Y N Examples: ____________________________

Do you have facial pain at other times? Y N When and how often? _________________

____

What relieves your pain? ____

Do you have headaches? Y N What triggers them? ________________________________

How often do you have headaches? ____

What relieves the headaches? ____

Do you have pain that interferes with daily activity? Y N Please describe: ______________

____

Do you feel your bite has caused damage to your teeth or mouth? Y N

Please describe:____

Have you lost any of your teeth prematurely? Y N Describe: _________________________

Do you have problems with you gums or have periodontal disease? Y N

Describe: ____

Are you aware if you clench your teeth? Y N

Do you have difficulty breathing through your nose? Y N

Do you have frequent sinus problems? Y N Describe: _______________________________

Do you Snore? Y N

Do you have difficulty sleeping? Y N Describe:____________________________________

Do you have daytime drowsiness? Y N

Have you ever been told you have obstructive sleep apnea? Y N If so, when? _________

Are you aware of any problems with your speech? Y N Describe:____________________

____

Have you had previous orthodontic treatment to attempt to correct your bite? Y N

Describe:____

____

Please describe any other problems you have because of your bite:

____

____

____