Brandon D. Smith D.D.S
Dental Arts of Hedgesville
ARTISTRY • INTEGRITY • PASSION

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MUSCULOSKELETAL SCREENING QUESTIONNAIRE

Referred by:_____Date:_____

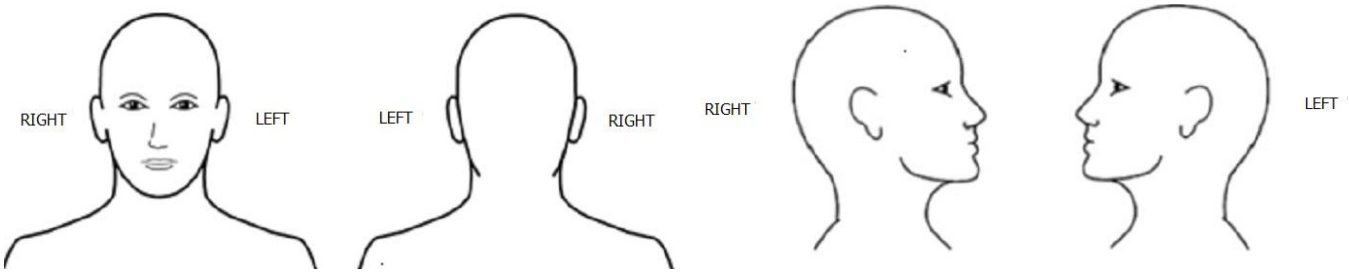

Chart:_____ DOB:_____ Patient Name:_____

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 placing an " X " in the appropriate areas.
(L = Left; R = Right)

a. Pain in the jaw (TMJ) _____ L R_____

b. Pain in the ear _____L R____

c. Pain around the eyes _____L R_____

d. Pain in the lower jaw _____L R_____

f. Pain in the neck _____L R_____

g. Pain in the shoulder _____L R_____

h. Pain in the forehead _____L R_____

i. Pain in the 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. _____
Most descriptive word *(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. Tingling in finger tips _____ Yes No _____

r. Headache _____Yes No_____

s. Fullness, pressure in ear _____L R_____

t. Pain in tongue _____Yes No_____

u. Limited opening of mouth ____Yes No ____
If yes, is it (1) Constant ☐
(2) Sporadic ☐

v. Difficult Chewing/pain _____ Yes No_____

w. Difficulty swallowing _____ Yes No_____

x. Loud snoring _____Yes No_____

y. Constantly tired _____Yes No_____

z. Mouth to breathe at night _____Yes No_____

aa. Clenching teeth _____Yes No_____

ab. Awaken with dry mouth _____Yes No_____
If yes, (1) Frequently ☐
(2) Rarely ☐
(3) Never ☐

ac. Grinding teeth _____Yes No _____

ad.. Sensitive teeth _____ Yes No _____

ae. Unstable bite _____ Yes No _____

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Chart:_____

DOB:_____

Patient Name:_____

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

   Date:_____Doctor:_____Location:_____

   Brief summary:_____

   _____

   Date:_____Doctor:_____Location:_____

   Brief summary:_____

   _____

   Date:_____Doctor:_____Location:_____

   Brief summary:_____

   _____

   Date:_____Doctor:_____Location:_____

   Brief summary:_____

   _____

2. Please write in any other pertinent information that has not been covered previously. Write on back of sheet if necessary.

   _____

   _____

   _____

   _____

   _____

   _____

3. Are you in litigation or are you planning litigation? _____Yes _____No

   If so, please explain_____

   _____

   _____

   _____

Patient's Signature:_____Date:_____