

**Harold Gelb, DMD**

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Since your condition began, which of the following have you consulted for treatment?  
Indicate year and amount of relief:

	Year	Major Relief	Some Relief	No Change	Felt Worse
Acupuncturist					
Allergist					
Chiropractor					
Dentist					
Ear, Nose, Throat					
Endocrinologist					
General Practitioner					
Gynecologist/OB					
Internist					
Neurologist					
Neurosurgeon					
Nutritionist					
Ophthalmologist					
Oral Surgeon					
Orthodontist					
Osteopath					
Physical Therapy					
Psychologist					
Surgeon (General)					
Other					

**Recommended Screening Questionnaire for TMD**

1. Do you have difficulty, pain, or both when opening your mouth (for instance, when yawning)? \_\_\_\_\_
2. Does your jaw get "stuck," "locked," or "go out?" \_\_\_\_\_
3. Do you have difficulty, pain, or both when chewing, talking, or using your jaws? \_\_\_\_\_
4. Are you aware of noises in the jaw joints? \_\_\_\_\_
5. Do your jaws regularly feel stiff, tight, or tired? \_\_\_\_\_
6. Do you have pain in or about the ears, temples, or cheeks? \_\_\_\_\_
7. Do you have frequent headaches and/or neckaches? \_\_\_\_\_
8. Have you had a recent injury to your head, neck, or jaw? \_\_\_\_\_
9. Have you been aware of any recent changes in your bite? \_\_\_\_\_
10. Have you previously been treated for a jaw-joint problem? If so, when? \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Do you:**

- |   |     |    |
|---|-----|----|
| 1. Do you wake up in the morning tired and foggy, not ready to face the day?            | Yes | No |
| 2. Have a stressful situation at home?  | Yes | No |
| 3. Have a decreased appetite?   | Yes | No |
| 4. Feel slow in energy or slowed down?  | Yes | No |
| 5. Feel easily annoyed or irritated?  | Yes | No |
| 6. Do you have headaches in the morning?  | Yes | No |
| 7. Do you have difficulty concentrating, being productive and completing tasks at work? | Yes | No |
| 8. Do you fall asleep easily during the day?  | Yes | No |
| 9. Do you nod off readily or fight to stay awake while driving                          | Yes | No |

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

**SLEEPING HABITS**

**Do you:**

- |  |     |    |
|--|-----|----|
| 1. Have a morning headache?                                  | Yes | No |
| 2. Sleep well at night?                                      | Yes | No |
| 3. Have trouble falling asleep?                              | Yes | No |
| 4. Take medication/alcohol to fall asleep?                   | Yes | No |
| 5. Wake up during the night?                                 | Yes | No |
| 6. Snore loudly each night?                                  | Yes | No |
| 7. Gasp for air in your sleep?                               | Yes | No |
| 8. Mouth breathe while sleeping?                             | Yes | No |
| 9. Do you have frequent pauses in breathing while you sleep? | Yes | No |
| 10. Do you wake feeling that you are choking or suffocating? | Yes | No |
| 11. Clench your teeth at night?                              | Yes | No |
| 12. Thrash your legs in your sleep?                          | Yes | No |
| 13. Feel exhausted upon arising?                             | Yes | No |
| 14. Wake up too early in the morning?                        | Yes | No |
| 15. Have stiff muscles in the morning?                       | Yes | No |
| 16. Feel rested upon arising?                                | Yes | No |
| 17. Have difficulty staying awake during the day?            | Yes | No |
| 18. Feel tired during the day?                               | Yes | No |
| 19. Read or watch T.V. in bed?                               | Yes | No |
| 20. Use two pillows?   | Yes | No |
| 21. Sleep on stomach?  | Yes | No |

Please note how much your "chief complaint" disturbs your sleep by circling the number on the diagram:

