smile by design DENTAL GROUP

Head Health History

Name: _____ Date: _____

1. Do you get Headaches Yes No
2. Do you get migraines headaches Yes No
3. Have you been in a car accident, major or minor? Yes No
4. Have you had sports injuries and/or trauma to your head & neck? Yes No
5. Are you aware of the noises in your jaw joints? POPPING CLICKING
   OTHER:_____
   Where? Right Side Left Side Both
   How Long? A year ago Less than a year ago
6. Do your muscles get tight or sore? Yes No
   When? Morning Evening After Chewing
7. Do you experience ringing or fullness in your ears? Yes No
8. Do you grind or clench your teeth? Yes No
9. Do you have pain or difficulty opening wide? Yes No
10. Do you have trouble sleeping soundly? Yes No
11. Daytime Sleepiness, drowsiness or tiredness? Yes No
12. Do you have trouble remembering things or paying attention during the day? Yes No
13. Do you snore at night? Yes No
14. Have you previously been diagnosed with sleep disorder? Yes No